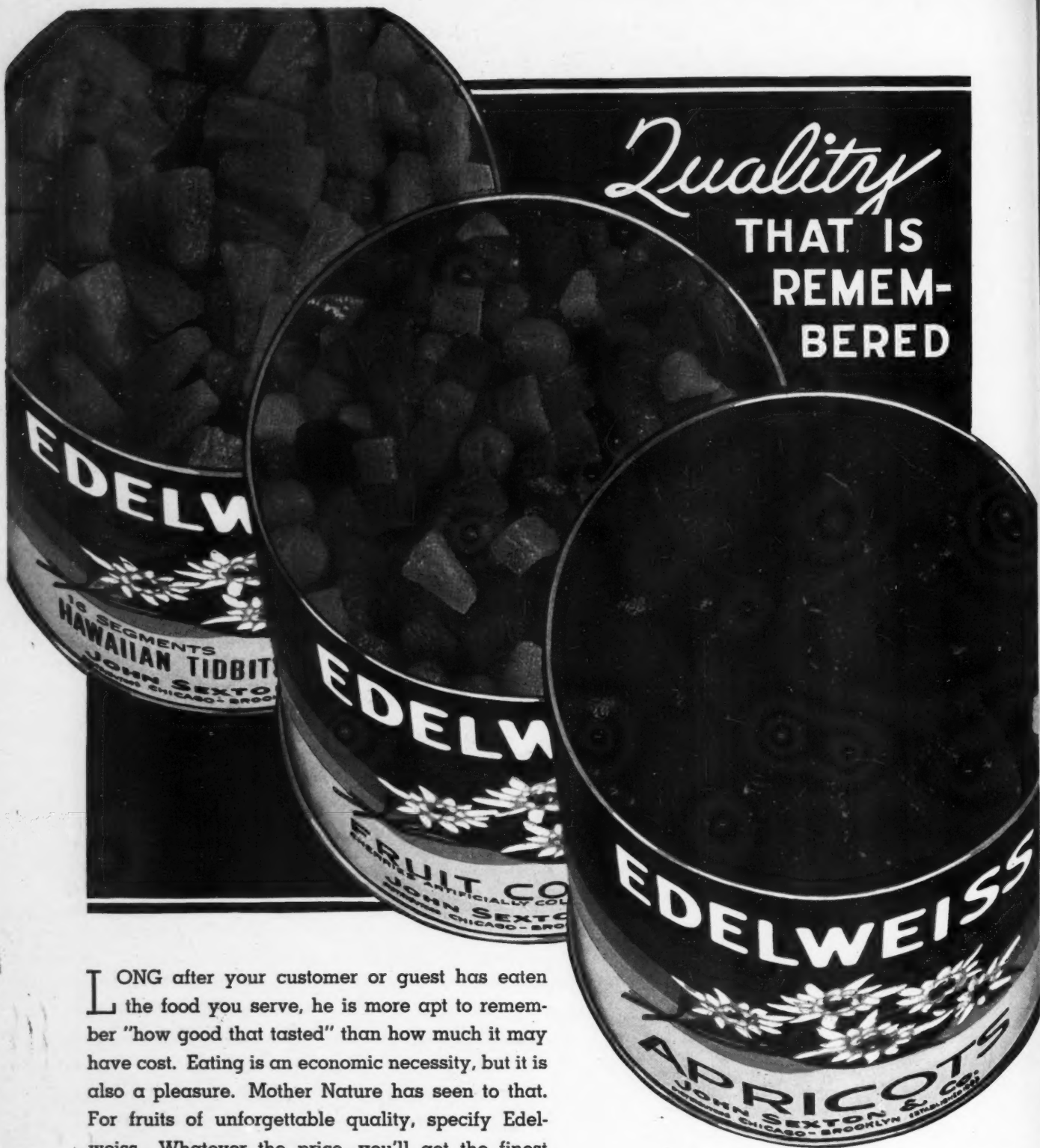


the
MODERN
HOSPITAL

VOLUME 48

MAY 1937

NUMBER 5



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MAY 12 is National Hospital Day as well as Coronation Day. So both the United States and the British Empire will celebrate. Special features in this issue about National Hospital Day include the article on the program at Wyckoff Heights by Mr. Sloan (page 44), another on the program at Mount Sinai Hospital, Philadelphia, by Ethyl Felt (page 72), a short article on Miss Nightingale and her famous cook, Chef Soyer, which appears on page 100 and a Hospital Day tray and a Florence Nightingale salad both specially created for The MODERN HOSPITAL.

THE economics of laboratory service in the hospital concern the pathologist, the administration and the patient. Much heat has been generated in discussions of this subject. Next month the current will be stepped up to provide light rather than heat. Dr. H. R. Fishback of Northwestern University, Chicago, will present in a series of three articles the results of a survey of laboratory economics. Armed with facts, our discussions should be revealing.

A NUMBER of hospitals have received complaints from employees because of the exemption of the hospital under the Social Security Act. Some administrators believe that the time has now come to bring their employees under the protection of the old age sections of the act. Others would go the whole distance and give their employees unemployment insurance protection also. Among the latter is Harry H. Graef, superintendent, Children's Hospital, Akron, Ohio. His statement on this vital question will be published next month.

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AN IMPORTANT study of the opinion of American medical men on the future of the practice of medicine has just been published. This was not an attempt to draw a statistical picture of medical opinion but rather to gather views from scientific leaders of the profession. Their thought-provoking utterances range over the whole field of medical work including medical education, specialization, group practice and social medicine. On the subject of the future of the hospital in medical service a progressive attitude dominates. Next month we shall present a brief summary of these views. Every alert administrator, however, will wish to have a copy of the complete report for thorough digestion. Its a bargain in books—1,600 pages for \$3.50—available from the American Foundation, New York City.

THE question of personnel relations comes up today whenever two hospital administrators meet. Its of top interest, and rightly so. Next month Dr. Benjamin W. Black, Oakland, Calif., will present principles of personnel administration that every hospital might well take to heart.

BELLEVUE HOSPITAL—there she stands. Doctors and nurses in every part of the civilized world look back to Bellevue as to their alma mater. But Bellevue, old as she is, has not yet succumbed to hardened arteries. Today again, Bellevue is building, not merely in physical plant but also in esprit de corps and in scientific attainments. Next month the story of Bellevue will appear in *The MODERN HOSPITAL*.

"THE Challenge of Chronic Illness," to be discussed next month, brings under review the diseases and conditions which make up this vast problem. Adequate care of chronic patients is necessarily expensive. Surely if any nation in the world can tackle this problem with a reasonable prospect of success, the United States can. Wealth we have, and medical science of a high order. We are beginning to arouse a social consciousness regarding chronics.

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The Editor Talks It Over

• To the hospital administrator as well as to the diagnostician, the possession of a highly developed power of observation is essential. Those who know of the exploits of Sherlock Holmes do not always appreciate the fact that Sir A. Conan Doyle, the originator of this unusual fiction character, practiced medicine before he became famous as a writer. Moreover, his old teacher in the Edinburgh Infirmary, Dr. Joseph Bell, served as the inspiration of his famous character.

It is related that Doctor Bell was able to learn more about a patient by a few quick glances than could most physicians by prolonged questioning and examination. On one occasion, so it is said, he remarked to a patient that he observed he had served in the army, had been recently discharged, had been a noncommissioned officer and had been stationed at the Barbadoes. All this information he secured because the patient did not remove his hat, had not been discharged long enough to learn civilian ways, had an air of authority and suffered with elephantiasis which is a West Indian and not a British disease. Verily, a good physician must be somewhat of a medical detective.

• It is a far cry from Sir Joseph Lister's "hot box" of 1872 to the splendid battery of sterilizers adorning the operating floor of the modern hospital. From this crude enclosure capable of applying heat as a sterilizing agent autoclaves of modern times have sprung.

• During early Listerian days the ingenious spray capable of filling the atmosphere about the operating table with some type of vaporized antiseptic came into common use not only abroad but in this country. Indeed two parties among physicians sprang up. Those who began their operations as remarked by a wag of the time by the exclamation "Let Us (S)pray" and those who refused to be intrigued by such an outlandish idea.

Robert F. Wier first brought to America from Lister's clinic this crude

apparatus which consisted of an alcohol lamp to generate the heat that activated a pump capable of spraying the air of an average operating room with 5 per cent carbolic acid solution. It was Lister who discarded the use of rags in the operating room in favor of gauze and inaugurated what some of his critics called "the gauze and spray method." It was he also who on Christmas Day, 1868, first used catgut as a ligature. It was Lister who devised the system of chromosizing catgut in order to prevent premature absorption.

• Have you ever wondered what the occupational therapist carries in her basket? These briskly stepping, green clad individuals seem to be going somewhere and to have a definite purpose. Wool and raffia, clay for modeling, leather for belts, are but the physical contents of the basket. To be sure, the skilled therapist may also have hidden therein an intriguing puzzle, a book of conundrums or some other trick of the trade to win the confidence of her prospective clients. Someone has wondered what becomes of all occupational therapists who have grown older, because most of the workers observed in hospital corridors appear so fresh and young and purposeful.

One should not be too inquisitive about ages. Perhaps the youthful appearance of the therapist is something of an illusion. Perhaps interest and pleasure in her work keep her appearing always young. At any rate, her basket contains more than the physical equipment for the practice of her profession. If one looks closely one will be likely to find there in great abundance less concrete materials which bring contentment and forgetfulness of pain to patients through tedious days of convalescence.

• Those who labor in hospitals must often marvel at the ability of patients and their friends and relatives to withstand the cudgelings of fate. What staunch properties of soul must be possessed by the husband who, arriving home from his work, discovers that stark tragedy has occurred in his home

through the accidental or intentional ingestion of illuminating gas by his wife. How rigidly must the wife control her emotions when she learns that her husband has been admitted to an accident ward of a hospital gravely injured as a result of an automobile accident. With what bravery must a wife be endowed who cheerfully seeks employment to support the family and her husband who has been stricken with an incurable cardiac ailment.

One does not need to seek only among hospital workers for those qualities of soul which never fail to arouse the highest admiration. Let him visit the wards of any institution and learn the stories of patients there. Let him sit at the desk of a medical social worker for but a brief spell and hear unfolded stories of physical and financial hardship staunchly borne. Such experiences have become so common that the hospital executive rarely has time to pause and admire when they are brought to his attention.

It might be well before passing judgment upon a patient's reluctance to meet the financial requirements of hospital care to search a little further and learn the facts in the patient's life drama or tragedy.

• A kindly surgical nurse recently asked a trusting little tot about what the doctor was to do for her on the morrow. Said she, "He will give me some medicine and my tonsils will jump right out." Would that this fairy tale, no doubt learned at her mother's knee, were literally true and that tonsillectomy consisted only of such an easy and rapid escape of the offending or offended organs from their pharyngeal hiding places.

• Again the danger of agents employed to remove adhesive plaster is brought to the attention of the medical and hospital world. A near fatal accident which occurred when a child inhaled vapors of carbon tetrachloride is reported from a Chicago hospital. Let the administrator again look into the safety of the adhesive tape removers used in his hospital!

Looking Forward

Insurance at Less Cost

AT LAST the approved hospitals are to receive definite cash benefit for their leadership.

All A. C. S. approved hospitals in the United States and Canada may now obtain comprehensive liability insurance under a special hospital contract at substantial savings.

This new contract, custom made for hospitals, is the outgrowth of many years' attention to insurance problems by The Modern Hospital and several months' intensive study of liability insurance recently.

It is also the outgrowth of the constructive standardization program of the American College of Surgeons which has raised standards of medical service, of administration and of physical plant.

Careful analysis of insurance experience shows that approved hospitals have a much lower loss ratio than unapproved hospitals. At present the hospitals which have expended the efforts and money necessary to comply with the standards of the college are not given sufficient credit for their better insurance experience. In other words, their premiums have not been reduced proportionately with the reduction of their risk.

This new hospital contract gives approved hospitals the benefit of the reductions in cost which they have actually earned. In no sense is it "cut-rate" insurance. It is more adequate protection at less expense!

Furthermore this new contract, unlike

most existing policies, is a simple, straightforward document practically without exclusions. It is a complete, comprehensive policy protecting the hospital, its officers, and, if they wish, the members of its medical staff. The protection of staff is not limited to work done in the hospital but protects them wherever they may practice.

The following hazards are covered by the new policy all in one contract: 1. "owners, landlords and tenants" liability, 2. malpractice liability, 3. elevator liability, 4. druggists and products liability, and 5. contingent liability.

"Owners, landlords and tenants" insurance protects against hazards relating to the physical plant or equipment. Thus it is applicable where a visitor, patient, trespasser or any other person not in the employ of the hospital slips on the floor, is injured by a falling cornice, falls on ice, or stumbles over equipment left in corridors, to mention only a few types of such accidents.

Malpractice insurance covers claims arising from alleged negligence upon the part of the doctor, the nurse, the laboratory technician or any employee or agent of the hospital. Examples of this type of claim are alleged improper diagnosis and treatment, failure to remove a sponge or instrument following operation, x-ray or hot water bottle burns, errors and mistakes in administering drugs.

The elevator clauses give protection against injuries which may occur through the maintenance and use of the elevators and any other hoisting devices.

Druggists and products insurance safeguards the hospital against losses arising from actual or alleged errors or mistakes in preparing, compounding, dispensing, selling or delivering drugs, food, merchandise or any other product. The need for this form of insurance is obvious. In addition to the heavy responsibility carried by the hospital pharmacist, there is danger of foreign bodies in the food, unsterile articles used in operating rooms, pins left in nightgowns and many other such sources of litigation.

Contingent liability covers claims that may arise from acts or negligence of independent contractors, subcontractors or their employees while working for the hospital.

In addition to the above, the new hospital policy provides defense of the hospital or its staff physicians in any lawsuit arising out of such claims. This is important since the costs of investigation and litigation frequently are greater than the damages awarded.

From the above, it can readily be seen that this new contract is a blanket, all-risk form. When the hospital buys this contract there is no need for any other form of public liability insurance, except workmen's compensation and automobile liability.

At the suggestion of The Modern Hospital, this insurance has been made available by one of the largest insurance organizations in the world. This organization agreed to provide it only after a careful study of the hospital field and full inquiry into the methods and meaning of the standardization program of the American College of Surgeons.

The success of this program will depend upon the cooperation given by approved hospitals. Already a considerable group of well known hospitals have provided valuable data on their own insurance experience. The further development of the plan will progress as rapidly as other hospitals join in this cooperative movement.

Change to Green Lights

THE click of signals changing from red to green is a heartening sound these days, denoting renewed progress in hospital service. In many communities the sign to "Go Ahead" has already been hailed with enthusiasm. Others are just getting under way. Reports from the East—New York, Connecticut, New Jersey and Pennsylvania specifically—reveal a resumption of hospital building and modernization indicative of the country at large. Every day brings new evidence of reviving hope on the part of trustees and administrators. Plans drawn in the long ago are being removed from the back of filing cabinets, the dust of years blown from their crackling sheets as they are unrolled on the directors' table. Steadily soaring costs lend impetus to fund raising campaigns for that new wing, that much needed nurses' home, that maternity unit.

The response to these appeals is significant, and may be taken as evidence of the public's appreciation of the distinguished service hospitals have rendered during recent difficult years. Results attest also to the willingness of the average individual to respond to hospital support once its needs are properly interpreted.

It is noteworthy that much of this activity emanates from suburban or rural districts whose hospital facilities have been sorely taxed of late. There the cry to rally to the support of "our hospital" is increasingly insistent. Demands greater than ever before placed upon old buildings reveal their startling inadequacy in modern procedure. Equipment long obsolete presents new hazards and inflicts responsibilities no official dare assume.

Small wonder, therefore, that the change of signals is welcome and that the general trend is forward. Go ahead? Why not?

A Crucial Race

AMERICAN voluntary hospitals are now engaged in a crucial race with rising costs. The urgent necessity of increasing wages, shortening hours, improving maintenance or giving adequate compensation for "living out" and providing social security to employed, involve heavy demands on hospital budgets. Furthermore, commodity prices are still rising.

Will costs mount so rapidly that they will outdistance increased income from greater occupancy, better collections, higher rates and larger aid from charitable and tax funds? If they do, voluntary hospitals may be financially crippled.

What are the true factors in this situation? Let us acknowledge them honestly. Only then are we in a position to build constructively.

First, employers as a class are today on the defensive in America. Public sympathy and public support are largely on the side of the employee. Hospitals as a group have been so backward in labor policies that they are particularly vulnerable. In most communities any crusading newspaper could, by giving only one side of the picture, conduct a highly effective campaign against hospital labor policies.

Second, many wealthy persons have grown tired of well-doing and now are saying "The government is taking such a large part of our incomes for social services, let government support hospitals." This is probably not characteristic of even a majority of actual or potential philanthropists. But there is a growing acceptance of this point of view. It is a tendency voluntary hospitals should stem.

Third, average citizens are indifferent to hospitals if indeed they do not actually dislike them. We haven't yet created in the minds of our supporting public a feeling of pride and an instinctively friendly response.

For these reasons the increased costs that are bound to come, will not be automatically counterbalanced by equal or greater income. Wishful thinking will not do. Action is demanded.

Weapons of Offense

THE best remedy for a poor defense is a powerful offense. What weapons of offense can we use to improve our financial position, strengthen our call upon philanthropy and create in large masses of people a basically sympathetic feeling for hospitals?

First, we must do everything possible to remedy the unsatisfactory aspects of our labor policies. Nor can we claim that it is impossible to meet our employees' requests if we are not administering our hospitals at a high level of efficiency. The inefficient administrator must make way for a thoroughly competent successor.

Second, we must point out with vigor to business and other leaders the essential values in voluntary effort. We must show them that if they fail us now, they will still have to pay as much of the bill for hospital care but to it will be added some percentage, small or large, necessary to meet the costs of bureaucracy, political inefficiency and lack of appropriate consideration of merit.

Furthermore, we must demonstrate by actions

as well as words that a given sum of money invested in a voluntary institution will bring a greater yield in community service than the same sum invested in a government hospital. There is no need for sweeping condemnation of government hospitals, many of which are doing splendid work. But the flexibility, creativeness and economy of voluntary effort must be demonstrated.

Third, we must pursue a vigorous policy of building friendship for hospitals among the rank and file of our citizenry. Fortunately, in group hospitalization plans, we have an almost perfect implement. Group hospitalization removes at one stroke one of the leading sources of annoyance and dislike. It furnishes a unique opportunity for the education of the public regarding the purpose, services and costs of our hospitals.

If group hospitalization is to be one answer, however, it should embrace as large a percentage of the total population of the country as possible. It must not be confined merely to certain classes in a few large cities. This means state or regional organization, and plans adapted not only to the white collar class but also to the people living on \$50, \$75 or \$100 a month. Experimental steps should be supported by hospitals.

Fourth, voluntary hospitals must view their service from the standpoint of the benefit to the whole community. A plan must be evolved for a balanced hospital program, like that being worked out for the New York metropolitan area. We must be ready to surrender some of our individual freedom of action so as to achieve the larger good of the whole community and the whole hospital group. The services of voluntary and of government hospitals must dovetail so that needless duplication is avoided and all necessary aid provided. Creative imagination must be applied to hospitals in order to insure full return on the public's capital investment in them. The potentialities of the hospital as a center of medical service and a strong arm of the community's public health program must be visualized and then realized.

Linked to the service program should be a comprehensive program for financial support of hospitals in each community. Once adopted this should be followed up with intelligence and vigor. This should cover all types of hospital activity—charitable, part-pay and full-pay service; educational and research work; out-patient as well as in-patient care, and special hospitals as well as general institutions.

Time is short. The financial pressure which we have felt in the past will soon be much strengthened. The time to act is now.

Hospital Day Comes to Town

By RAYMOND P. SLOAN

STRIKE up the band, the high school band! The show is on! An imposing array of headline attractions awaits you—motion pictures, illustrated talks, demonstrations and refreshments, too. This way, ladies and gentlemen—this way to the big show. Welcome to Hospital Day at Wyckoff Heights!

Even as these words are read the actual scene may be taking place in the buildings and on the grounds of Wyckoff Heights Hospital in Brooklyn, N. Y. The date is May 9, which happens also to be Mothers' Day. Upwards of two thousand visitors stream through the gates where they are warmly welcomed by the ladies auxiliary and members of the nurses alumnae association who take them in charge and help them enjoy to the utmost the program that has been carefully prepared for their benefit.

Two thousand visitors all in one day sounds like a big order for a 200-bed hospital. It is, but it is also an exceedingly profitable order which pays substantial returns throughout the year. Moreover, it is not so difficult to execute as it may seem. It all depends on the amount of care in the handling.

There are those who maintain it just isn't practical—Hospital Day in the big city. All well and good in smaller centers where the hospital functions as a community agent, but the problem of the metropolitan institution with its ever shifting population is quite different. Fraternizing with the populace can't be done. Yet surely the city hospital needs public support to as great if not greater extent than the so-called community hospital!

Wyckoff Heights is not large as hospitals are judged these days, but it is a big city hospital nevertheless, tucked away securely in the outskirts of Brooklyn, the Ridgewood section, as it is known. What elements of community life formerly existed are fast fading as the city stretches out persistently toward the more open areas of Long Island. All of this notwithstanding, its residents have been made completely conscious of the



Candid camera catches

service it is rendering, and have become increasingly interested in contributing to its advancement. To that section of the city at least National Hospital Day means a visit to Wyckoff Heights and personal inspection of its many wonders.

It developed in the most unexpected manner. About five years ago Louis Schenkweiler, superintendent, was invited to speak before the Kiwanis Club. He determined there was one thing he would not do—ask for money. So he confined his remarks to hospital service in general and ended by inviting forty Kiwanians to be the hospital's guests at luncheon on National Hospital Day. With certain misgivings as to the success of the undertaking, for Hospital Day up to that time had met with but little response, he invited others to inspect the buildings during the afternoon.

They came, they saw, and Wyckoff Heights conquered. The Kiwanians even volunteered to pay their own way, and the hospital was the recipient of a check for \$50. Attendance at the luncheon and during the afternoon totaled one hundred, much to the surprise and satisfaction of Mr. Schenkweiler and his trustees. From then on there has been no question about it. National Hospital Day has come to stay in the Ridgewood section of Brooklyn.

During the ensuing years attendance at these annual events increased steadily. The second year

it jumped to 700, then to 1,200. Last year it was 2,000, and what is in store for 1937 no one knows. The weather, of course, is an influencing factor. So far no deliberate effort has been made to follow up ex-patients with special invitations. That may come later. Right now the hospital is sufficiently occupied in catering to groups of trustees, contributors, members of the Wyckoff Heights Hospital Society which has a membership of 700, to churches, civic organizations, mothers' clubs, and political bodies. After all, there is a limit to the number of people that can be handled between the hours of one to four.

Two questions are probably uppermost in the minds of those who, having read thus far, hesitate, whether or not to turn the page. Very logical questions, too. So before describing the Hospital Day program at Wyckoff Heights in detail, let's try to answer them.

Should a hospital inflict upon its frequently inadequate personnel the added burden of entertaining two thousand people in the space of a few hours, and what about this thing we so fondly refer to as hospital routine? Second, can a hospital afford to entertain on so lavish a scale?

If the superintendent is a competent organizer the chances are his department heads and aids will possess sufficient loyalty to be willing to contribute a few additional hours of labor. They will have been made to realize the need for creating

RIDGEWOOD TIMES, FRIDAY, MAY 8, 1936

Await "National Hospital Day"

"Open House" Sunday
At Wyckoff Heights

to Inspect Entire Facilities of Ridgewood
P.M.—Interesting Program Arranged

For TWO
HOSPITAL DAY
OBSERVANCE ON
MAY 10TH HERE

Motion Picture, Talks to
Public, Inspection of
Entire Facility

Wyckoff Hts. Plans For
National Hospital Day

Demonstrations, Talks, Public Inspection
Motion Picture and Free Refreshments Ar-
ranged for Sunday, May 10th—Organizations
and Residents of Community Invited to Visit

Page TWELVE
WYCKOFF HEIGHTS
MAP BIG PROGRAM
FOR HOSPITAL DAY

Invited to
Inspect
Hospital

We shall be pleased if you will invite your friends
to visit our hospital on May 10th, National Hospital
Day. On that day, from 1 to 4 P.M., visitors will
be escorted through the hospital and made familiar
with some of the inner workings. We promise a pleas-
ant afternoon with refreshments served at no cost.
Louis Schenkweiler,
Superintendent.

Pathological Department
One of Most Important

Last Year About 20,000 Examinations Made At Wyckoff
Heights Hospital—Essential in Arriving At Facts Concerning
Patient's Condition

Those who visit Wyckoff Heights Hospital
May 10, will be given an opportunity
to see the pathological laboratory, one of
the most important departments of the hospital.

RIDGEWOOD TIMES, FRIDAY, MAY 15, 1936

"Hospital Day" Visitors
See Emergency Operation

HOSPITAL DAY
IS CELEBRATED

National Hospital Day was celebrated at Wyckoff Heights Hospital yesterday with many visitors. The program included a motion picture, talks to the public, and a free inspection of the entire facility. The hospital was open from 1 to 4 P.M. and was crowded with visitors. The program was a great success and many visitors were impressed with the hospital's facilities and the work of the staff.

OVER 1000
TO VISIT WYCKOFF
HEIGHTS HOSPITAL

More than 1,000 visitors are expected to visit Wyckoff Heights Hospital on Sunday, May 10, for National Hospital Day. The hospital will be open from 1 to 4 P.M. and will be crowded with visitors. The program will include a motion picture, talks to the public, and a free inspection of the entire facility. The hospital is a modern and well-equipped institution and the staff is highly trained and efficient. The program is a great opportunity for the public to learn more about the hospital and the work of the staff.

Fund Drive.

a wider and stronger public interest that the hospital's doors may be kept open, and their jobs made secure. Entertainment of the public cannot be accomplished, of course, at any sacrifice to the hospital work. For this reason Sunday afternoon is perhaps best for National Hospital Day activities.

The extent to which the hospital should become involved financially in its entertainment program rests again with the superintendent and the staff and the care with which they make preliminary plans. The two thousand visitors at Wyckoff Heights last year were entertained, believe it or not, at a total cost not exceeding \$50. This was for printing and publicity and the services of an extra baker for two days. Money well spent, that housewives of the neighborhood might get a taste of hospital baking.

Everything else was contributed. The local dairy donated the ice cream — and plenty of it, sufficient even for extra portions. The company that regularly supplies the hospital with coffee obliged to the point that not a single guest was overlooked. The mortician provided camp chairs, and even the stationery store down the block furnished paper plates for the ice cream.

Rounding up such donations requires time and effort. This task was undertaken by the president of the nurses' alumnae association who with two willing and able assistants spent evenings and hours off duty soliciting the tradespeople personally. The result was an abundance of gifts. Flowers and potted plants in profusion were loaned for the occasion. One small florist in the neighborhood who was overlooked actually felt he had been slighted and sent some flowers anyway.

This year much the same procedure is being followed. A committee comprising four members of the nurses' alumnae started early in April to

discuss plans for the May event with Mr. Schenweiler and Arthur H. Labaree, editor of the *Samaritan*, a little bulletin issued five times each year by the hospital.

This booklet, by the way, plays an important part in the Hospital Day program in providing a medium for valuable publicity. And publicity carefully prepared has been largely responsible for the success of these May parties. Four issues are distributed regularly each year, sent to some two thousand names. The cost of editing, printing and mailing, incidentally, is about \$125 an issue. A fifth issue placed in readers' hands a short time before National Hospital Day is devoted exclusively to that event, giving the details of the program and inviting attendance.

Bulletin Broadcasts News

Before even this special number is off the press, friends of the hospital have been advised of the date in a regular issue of the *Samaritan*. For example, let us see what the April, 1937, issue has to say.

"Last year 2,000 visitors thronged our hospital on Sunday, May 10, and enjoyed an instructive afternoon inspecting the various features of our hospital plant, viewing demonstrations, hearing short talks, and finally enjoying a concert and refreshments on the lawn adjoining the main building. The concert was provided by the orchestra of Grover Cleveland High School, which it is hoped may again entertain the hospital's guests this year. Another interesting and instructive program is being arranged, and it is expected that the visitors will be more numerous than ever."

In addition to announcements in the *Samaritan*, publicity articles are sent regularly to all local newspapers, these releases continuing until the final account of the reception appears. The *Ridgewood Times*, for example, carried on May 15 last, an article headed "Hospital Day Visitors See Emergency Operation — An unexpected example of hospital work in the form of an emergency operation was witnessed by some of the 2,000 visitors who thronged Wyckoff Heights Hospital last Sunday in observance of National Hospital Day. A patient was admitted suffering from acute appendicitis. An immediate operation was decided upon.

"One of the operating rooms had been held in reserve for just such an emergency. Through the glass of the connecting door with the adjoining operating theatre, early comers among the visitors caught glimpses of the surgeons at their work. The operation was over by 2:30, and those who came to visit the institution from then until



4:00 saw the regular program of demonstrations, exhibits, a motion picture, and heard talks."

One other method is used to invite attendance. A neat printed invitation signed by Mr. Schenkweiler is placed in the patients' rooms. "We shall be pleased," it reads, "if you will invite your friends to visit our hospital on May 12, National Hospital Day. On that day from 1 to 4 p.m. visitors will be escorted through the hospital and made familiar with some of the inner workings. We promise a pleasant afternoon with refreshments served at no cost."

Assuming that certain fundamental questions regarding National Hospital Day in a big city have been answered to the reader's satisfaction, and that he is still turning pages with us, let us imagine ourselves as part of the throng that this very minute may be surging through the gates of Wyckoff Heights. That attractive lady who greets us and invites us to register in the basement is a member of the Ladies Auxiliary. She tells us that our guide through the hospital will be a member of the nurses' alumnae association.

"No, I'm exceedingly sorry, but we don't permit children to go through the hospital," she explains to the young woman with two small boys who stands directly behind us. Then detecting a look of disappointment on the mother's face she adds, "You see we have put an age limit of sixteen on our visitors. But I wonder if the children wouldn't be happy with me for a few minutes while Miss Cornu takes you through. Perhaps a little ice cream would help them pass the time."

The Line-Up for the Day

Quicker than actually making the trip to become better acquainted with the entertainment offered will be the outline which the *Samaritan* supplies. This year's program is practically the same as that of last May.

"The visitors will congregate in the basement, where they will sign the guest register. They will be placed in groups, each with a competent guide from the nurses' alumnae association. Each group will first be taken through the dispensary, and the pharmacy. They will see one of the accident rooms and then will ascend to the fourth floor in the new elevator. Points of interest there will be the x-ray department, the anesthesia room, the operating rooms, the cystoscopy room and the instrument and sterilizing rooms.

"In the x-ray department, technicians will display films demonstrating the efficacy of the x-ray in locating foreign bodies and revealing abnormal conditions. A short explanatory talk will be given as the films are shown. In the operating rooms, staff surgeons will give demonstrations of surgical

technique, and hospital nurses will explain and demonstrate the use of the sterilizers and the equipment for administering various forms of anesthesia. The departments on the operating floor have invariably proved among the most interesting to visitors, who, last year were able to get glimpses, through a glass door, of an actual emergency operation then in progress.

"Descending to the third floor by the main staircase, points of interest will be the children's wards, the private and semi-private rooms and the pantry and utility rooms. Going down a rear stairway to the second floor, visitors will see the women's ward and private wards, the maternity ward, pantry and utility rooms, and through large glass doors, they may see the nursery, with the newborn infants in their bassinets.

"The guides will lead their charges down the main stairway to the entrance lobby on the first floor, where they will see the men's ward and the



semi-private rooms and wards. There will then be an inspection of the pathological laboratory, where technicians will demonstrate some of the many tests made as an aid to diagnosis and explain them to each group.

"To the housewives, burdened with a small weekly wash, the guides will next show the laundry, where thousands of pieces of linen are washed and ironed each year, and, finally, they will see the sewing room, where the linen is mended and kept in repair.

"Via the laundry stairway, the visitors will descend to the basement to see the dining rooms for hospital staffs and personnel, the diet kitchen, the main kitchen, where 900 meals are prepared every day throughout the year, and the store-rooms and refrigerating plant. In the main kitchen, the groups will see hospital chefs preparing not only the evening meal of the day but the refreshments of which the visitors will themselves partake at the conclusion of the program.

"Each group will then leave the main building and proceed through the yard to inspect the Hy-Colon bath department, the engineering department, housing not only the heating plant but the hospital's own ice manufacturing plant. The carpenter and paint shops, for the repair and maintenance of hospital equipment, will interest the men, as will the garage and ambulances. The latter, when not out on calls, will be drawn up in the yard and their chauffeurs will explain the

many interesting features of these miniature hospitals on wheels.

"Numerous features of interest still await the guests as they reach the auditorium of the nurses home where members of the ladies' auxiliary will act as receptionists. Each group will see displayed a film entitled, 'The Story of My Life, by Tee Bee,' picturing the fight against tuberculosis. There will also be a series of short talks in the auditorium, one describing the popular three-cents-a-day hospital plan, another on the ambulance and dispensary service given by the hospital and one on 'Community Relations.'

"Finally, if the weather is good, the groups will leave the auditorium and gather on a spacious lawn adjoining the main building, where members of the junior ladies' aid society will be in charge of the reception, seats will be provided and refreshments will be served."

So, let's strike up the band. The show is on, and what a show it is! Talk, talk, everywhere — "My dear I took one look at that skull and I could feel the shivers go up and down my spine. He did look cute, though, didn't he? No, of course, I meant that young intern with the curly hair. Ice cream? Why, I don't mind if I do, and just a bit of that delicious looking cake. What's that, buttons they're giving away? Sure I'll take one, and wear it, gladly. Might as well let our friends know we've been celebrating — celebrating National Hospital Day at Wyckoff Heights."

Find Bed Shortage for N. Y. C.'s Tuberculous

THE sharp rise in the incidence of tuberculosis in New York City last year was laid directly to the shortage of hospital beds for the tuberculous by Dr. Haven Emerson, professor of public health practice at Columbia University School of Medicine, when he made public the findings of a two-year tuberculosis study by the Hospital Survey of New York.

"Last year, for the first time since 1917," he said, "the death rate and incidence of new cases of tuberculosis rose sharply, not because of any wave of influenza, not because of any deficiency of nutrition, not because of any new or harmful industry, and not because of any housing crisis or overcrowding, but for the plain and obvious reason that patients left at home, excluded from hospitals, kept waiting months for a chance of care, were coughing and spitting among children and other housemates, causing a crop of new cases

in acute and progressive stages of the disease."

Statistics which had been compiled showed that the number of deaths from tuberculosis had increased 215, and the number of new cases, 225 over 1935. The immediate addition of 2,500 beds, Doctor Emerson told members attending the annual meeting of the New York Tuberculosis and Health Association, the Association of Tuberculosis Clinics of New York City and the Tuberculosis Sanatorium Conference, for whom he previewed the about to be published report, is imperative.

The situation with respect to shortage of beds for the tuberculous does not exist with regard to any other disease or group of patients, the survey showed. It was felt that adequate facilities for prompt hospitalization of the patient with frank pulmonary tuberculosis should have priority in any program in New York City.

Are There Enough Beds? Or Too Many?

By MICHAEL M. DAVIS

ARE there enough hospital beds to satisfy doctors, donors, taxpayers, building contractors, architects, administrators and the needs of the sick? What are the needs of the sick for hospital care? How shall they be measured?

The 440,000 beds in general hospitals in the United States are as unevenly distributed as our population—indeed much more so. The ninety-three cities with over 100,000 inhabitants possess a total population of about 36 million and 218,000 general hospital beds. At the other end of the picture 31,000,000 people live in towns and in rural areas which possess altogether only about 42,000 beds. In other words, cities with 28 per cent of the total population of the United States possess 50 per cent of all the general hospital beds, while 25 per cent of our people live in areas which have less than 10 per cent of the beds. In fact, conditions in our cities and in our rural areas are so widely different that the questions which head this article have to be discussed quite separately for the urban and the country districts respectively. This article will deal only with hospital beds in cities.

There has been little hospital building since the depression began; little, at any rate, as compared with the amount that had taken place during the twenty years previous. During those two decades it is probable that the investment in new hospitals and in expanding existing institutions ran from \$100,000,000 to more than \$200,000,000 a year. Are we now, when "prosperity" seems to have come around the corner, at the beginning of another building boom in hospitals? Should we have a boom? If so, how big a one? What facts and what principles are available for the guidance of those who are considering whether they will devote their money or induce philanthropic persons or taxpayers to give money for more or for bigger hospitals?

The reasons for the establishment of new hospitals or the enlargement of existing ones might be classified in two groups: first, the needs of communities, second, the needs or desires of in-

Cincinnati has 8.4 beds per thousand population while Chattanooga has only 3. Why the wide variations? How can we determine the correct supply and how can we achieve it?

dividual hospitals. A few communities, through their government or through an organization of representative citizens, have studied their hospital needs as a whole and tried to plan capital expenditures for hospitals in terms of what their people need and would support. On the other hand, some hospitals have sunk a legacy or the proceeds of a special financial campaign in a new building or in a hundred additional beds, although a larger number of beds had been standing vacant for several years past in the general hospitals of their city. Private pavilions have been built for the staff surgeons of a particular hospital to fill, at a time when ward beds in the community were far below the demand for them. Institutional desires are by no means identical with community needs. Capital investment is also made for improvements which do not increase the number of beds, for example, reconstructing an old building or putting up a nurses' home, an out-patient department, an operating suite or a power plant.

Mental and tuberculosis hospitals, the two large groups of special institutions which altogether have nearly 600,000 beds, must be considered separately from general hospitals. About 95 per cent of mental hospitals are government institutions, the majority supported by the states. The ratio of mental hospital beds to the population varies widely. New Mexico has less than 2 mental beds per thousand population; Massachusetts, nearly 7.

A special study made by the National Committee on Mental Hygiene in 1934 showed many institutions overcrowded even in some of the states with the more extensive provisions. If the ratio of beds to population in the wealthier states were taken as a standard, about a quarter of a million additional mental beds would have to be built to bring all parts of the United States up to this level. These figures are not stated as a recom-

mendation but as merely illustrative of a question which requires local study in each state before it can be rightly answered.

The National Tuberculosis Association has recommended a minimum standard of one tuberculosis bed to be provided for each annual death from tuberculosis, although this standard is in process of reconsideration with the probability that it may be revised upward. In 1934, the number of deaths reported from tuberculosis was 95,000. Contrasts between the states are wide. Thus there are seventeen states in which the tuberculosis hospital beds approximate or exceed one and one-half beds per death, whereas there are thirteen states in which there are less than three-fourths of a bed per death. In tuberculosis as well as in mental diseases, changes in methods of treatment and the use of beds in general hospitals for these conditions influence the number of beds needed in special institutions.

The recent study of the American Medical Association showed that some 40,000 beds in general hospitals were utilized more or less continuously for tuberculosis cases. The use of pneumothorax and the diagnosis of more cases in early stages through x-ray, may possibly reduce the number of beds needed for tuberculosis. But a full supply of beds in one state cannot be used to make up a shortage in another and there are more than a dozen states (mostly, but not all, in the South) in which beds for tuberculosis are greatly deficient.

Provision for Chronics Inadequate

Patients with chronic disease represent another large group of sick persons for whom the bed provision is admittedly inadequate almost everywhere, either in general hospitals or in special institutions. Estimates of two beds for chronic cases for each thousand persons in the general population have been used as a rough standard, but the adequacy of this standard for any particular community cannot be determined without special local study. A clear-cut definition of a "chronic case" must be agreed upon. The number of such cases in general hospitals must be determined by actual review on sample days. Cases in special and custodial institutions must also be surveyed, as well as chronic patients who are cared for in their homes but who should be hospitalized.

Thorough studies of this kind have been made in New York City. In Massachusetts, studies of chronic diseases, particularly of rheumatism have been carried on since 1931. A state commission, "To Study and Investigate Public Health Laws and Policies," reported last December that in 1935, cancer, the diseases of the circulatory system, dia-

betes and rheumatism comprised 63 per cent of all deaths, as compared with only 14 per cent in 1870.

Care for chronics will soon be of major importance to many general hospitals, as the proportion of older persons in our population increases and as more attention is given to chronic conditions as the result of welfare legislation. Plans for the fuller utilization of existing hospital beds and for the construction of additional beds must take chronic disease into account. The problem involves the medical staff as well as administration and finances.

In many of the community hospital surveys and in much that has been written about hospital needs in cities, the figure of 5 general hospital beds per thousand population has been taken as a standard of "need." How was this "standard," if it is one, originally determined? How reliable is it? These questions can be answered from the standpoint of theoretically estimated needs for hospitalization,¹ but let us rather look at some of the facts of general hospital beds in different cities.

Factors of Error

Take first the ninety-three cities which had over 100,000 population in the 1930 census. Definitions of what constitutes a hospital bed, as statistically reported, differ in practical use. Bassinets for newborn babies may or may not be included. Beds in isolation or observation wards may or may not be reported as hospital beds. Leaving these factors of error aside and taking the figures of general hospital beds from the last annual census of the American Medical Association—the best existing figures—we find substantial variations among cities in the same part of the country, or even within the same state. Thus Cleveland shows 5.7 beds per thousand; Cincinnati, 8.4; Syracuse reports 5.1 beds per thousand; while the figure for Utica is 7.8 and for Albany, 8.4. For Chattanooga it is 3 per thousand but Knoxville's is 5.6 and Memphis', 8.9. In Massachusetts, Somerville runs as low as 1.6 beds per thousand, but the figure rises to 2.2 in Lynn, to 4.2 in Lowell, to 5.1 in Worcester, to 6.0 in Fall River and in Boston it is up to 8.4.

In some instances one can see reasons for these

¹Several sickness surveys and the experience of hospital insurance plans indicate that one day's care per person per year in general hospitals is a rather full allowance for an urban population. Translated into beds needed, this works out as about 2.75 beds per 1,000 persons at 100 per cent occupancy, 3.4 beds at 80 per cent occupancy, almost 4 beds at 70 per cent occupancy and 5 beds at 55 per cent occupancy. Dr. Roger I. Lee and his associates, in their study of "The Fundamentals of Medical Care" (University of Chicago Press, 1933), page 119, estimated that 4.6 beds in general hospitals (at 80 per cent occupancy) were needed per thousand population, but this includes nearly one bed per thousand population for communicable diseases, a very much larger proportion than is normally hospitalized particularly in general hospitals. The Lee-Jones estimates thus work out to about 4 beds per thousand population at 80 per cent occupancy or 5 beds at 64 per cent occupancy. But neither this nor any similar "standard" can be applied to any particular city or county without careful local study.

differences. Thus the abnormally small number of beds in Somerville is undoubtedly due to its close proximity to Boston. The same reason doubtless accounts for the contrast between Los Angeles with reported beds of 4.9 per thousand and its satellite city, Long Beach, with only 2.8. One might guess that Memphis has a high rate because its hospitals serve a large surrounding population in three states. But no one who runs down the list of these 93 cities can find, from an examination of the statistics themselves, any rational basis for the widely varying ratios of beds to population. One is led merely to the conclusion that any explanation of the differences would require knowledge of local conditions. This means special local study in each case.

Among the conditions which will influence the number and utilization of hospital beds in a city are such factors as the following: the attitudes and customs of the local physicians towards hospital care for medical conditions, surgical conditions and maternity cases; the attitudes of various sections of the general public on these same matters; the degree to which hospital staffs are open or closed to the reputable physicians of the locality, or to particular groups thereof; the incomes and paying power of the local population; the presence of a medical school; the presence of a government general hospital; the degree to which local hospitals exist in small cities and towns adjacent to the larger center, and last but not least, the extent to which hospital beds in a city care for non-residents.

How Shall We Estimate Needs?

The last factor is important and we have little definite information about it. Some information is obtained by contrasting the bed provisions in the ninety-three cities with those in the counties in which these cities are included. Taking the hospital beds in the ninety-three cities and comparing them with the population of the cities alone, we find nearly half of these cities showing 6 beds per thousand or more. But if we take the ninety-three counties as wholes (including the cities), we find more than half of the counties showing only 4 beds per thousand population. In other words, if hospital surveys of cities include the county of which the city is a part, they will often show two beds less per thousand population than if the municipality alone is considered. Now, should a surveyor take the county, or only the city, as a population base for estimating hospital needs? The question cannot be answered unless we know how much the hospitals within the city actually serve the people of adjacent areas.

In some of the hospital surveys a canvass of

patients was made through which it was possible to determine the number who came from outside the city limits. Reviewing ten surveys made at various times in different cities, the proportion of patients coming from outside the city ranged from 10 to 36 per cent. Chicago hospitals were estimated in 1935 to have 10 per cent of nonresidents. The low figure of 12½ per cent was reported in the Cleveland Survey of 1920 and in St. Louis in 1924; and the top figure, 36 per cent, was shown in Louisville in 1924. New Haven and Providence, surveyed in 1928 and 1929, showed 33 per cent; Philadelphia and Washington, D. C., showed 19 per cent. To strike an average of these figures would be more misleading than helpful. It seems probable that in most of our larger cities not less than 1, and sometimes as many as 2 beds per thousand population are utilized by or must be kept available for nonresidents of the community. This figure is so large that it is of major importance in determining the need for hospital beds in a community. A study of the utilization by non-residents should be a part of every hospital survey.

Occupancy Rate Must Be Considered

It must be remembered that every hospital bed in a city which is utilized by a nonresident of the city means a hospital bed not needed in some community outside of that city. This partially explains the contrast between the cities and the rural areas. The survey of ninety-six communities recently made by the United States Public Health Service may give us more information on this matter than we have ever had before.

The occupancy rate in general hospitals is another large factor which has been too little considered in estimating needs for beds. Even before the depression, the occupancy in many general hospitals was only about two-thirds of their rated capacity and during the depression the figures have often sunk to 50 per cent or less. Generally speaking, occupancy rates in voluntary hospitals run higher in the larger institutions and lower in the smaller ones.

The depression showed in a dramatic way how greatly the utilization of hospitals is influenced by the economic factor. Free beds available in government hospitals have been overtaxed whereas free beds have had to be restricted in many voluntary institutions because the latter could not afford to keep them going. Low occupancy in many voluntary hospitals has been due in great measure to less use of hospitals by people who would have come in as private or semiprivate patients if they had been able or willing to pay the cost. It is also

¹ J. A. M. A. March 27, 1937, pp. 1029-1033.

true that during a depression some physicians are less ready to hospitalize certain types of patients.

As brought out recently by Charles F. Neergaard,¹ the so-called emergencies or peak loads for which hospitals must keep reserve capacity shrink on investigation to much smaller compass than hospital financial campaigns have usually led the public to believe. Potential givers, budget committees of community chests and tax spending officials need be no less sympathetic with hospitals even if they approach proposals for new capital investment with the attitude of critical inquiry. Hospitals may rightly be regarded as an expensive and inflexible type of investment. The number of beds cannot be suddenly altered and once hospitals have been built it is practically impossible to convert the buildings to other uses. Hospitals are not physical facilities which can be expanded or contracted in accordance with changing economic conditions. If the purchasing power of consumers of hospital service can be more stabilized, the utilization of hospitals will fluctuate less with the ups and downs of the business cycle.

Simplifying the Problem

Group hospitalization, middle rate plans, flat rates for certain combinations of services, larger use of tax funds, medical care insurance schemes in which physicians participate, rural cooperative associations for financing hospital care—these are measures which may diminish the wide fluctuations in the consumer's buying power for hospital service and may simplify this problem in the future. Certainly it must be simplified if hospital facilities are to be planned for on a reasonable basis.

In most hospitals for mental illness, tuberculosis, chronic diseases and in many city and county general hospitals, the general practitioner and the surgeons have little or no private practice. The demand for expanding these hospitals arises from either a sense of community needs or from political considerations. In a majority of voluntary hospitals, pressure for expansion may spring from a sense of community needs but may also arise from the ambitions of trustees and administrators and from the demands of staff members for enlarged facilities for their private practice. In the years just before the depression, the institutions which had strong staffs with growing practice were likely to expand. Memorial gifts led to other expansions which had little reference to community needs. The depression put institutional ambitions into cold storage, but they will lift their heads high again when prosperity raises the temperature.

Money for hospital construction or reconstruc-

tion comes either from tax funds or from voluntary gifts. Cities, counties and states have had considerable success in getting popular votes for bond issues for hospitals but the possibilities of enlarged tax appropriations or public borrowings to build hospitals will vary with locality and with the competing demands upon government revenues. Voluntary gifts sometimes come as windfalls, sometimes blossom as a result of long, sedulous cultivation and sometimes are the fruit of an intensive financial campaign.

To secure either tax or voluntary funds for construction or reconstruction, the most important thing of all is public confidence in hospitals. Competition among hospitals and individual expansions without reference to community needs will diminish public confidence in the long run. So will low occupancy rates. The voluntary hospitals as a group cannot afford to continue with low occupancies, particularly where there is growing public interest in certain types of cases, such as chronic illness, which these hospitals have not been accustomed to accept. Empty beds are a poor basis of appeal for either capital gifts or maintenance funds.

The sources of hospital capital are commonly such as to make much of it non-interest-bearing. Hence the fixed charges which business investments must consider have commonly been ignored in considering capital costs and costs of replacement. Largely for the same reason, depreciation allowances have not been set aside. The underlying issue is not how accountants shall estimate capital costs, but how future capital investment shall be regulated in the interest of the community.

"Standards of Need" Should Be Revised

The coming years will place more responsibility than ever before on those who are called upon to investigate hospital needs. This responsibility sometimes falls upon administrators who must report to the governing bodies of their own hospitals; sometimes upon consultants specially engaged by individual hospitals or by community committees. It would be advantageous if disinterested permanent agencies were to conduct some of these studies. The "standards of need" used in the past should be subjected to criticism and revision. More attention should be given to factors which concern the community as well as the hospitals. More emphasis should be placed on factors which involve all the hospitals of a community and not merely one particular institution. If present trends continue, the future of each will be more and more bound up with the interests of all institutions.

Mother Nature—Assistant Therapist

By C. H. CREED, M.D.

THE character of state hospital farms in Ohio varies according to the location. Some are situated where the land is rich, level and ideal for cultivation. Others are in hilly country where the land is poor and tillable plots are few and scattered, sometimes distant from the hospital, thus necessitating the consumption of valuable time in transporting machinery, materials and workers. In spite of such handicaps, the advantages more than compensate for the disadvantages.

The farm is of importance to the hospital in so many ways that to mention them all would make this article far too long. For the sake of system and convenience, the advantages are presented from four standpoints—esthetic, dietary, economic and therapeutic.

It is said that there is beauty in everything and there are always some who perceive it. Wild, unkempt, brush-grown land is beautiful to many but such a wilderness on the property of a state hospital would not appeal as would well kept and well tilled land. The orchards, the long straight rows of potatoes, corn and other growing vegetables with their various shades of green, the fresh coloring of the acres of alfalfa, the expanses of well kept lawns, beautiful flower beds and shrubbery, are a source of pleasure and pride to patients.

The beauty of the grounds of some hospitals is enhanced by lakes on which are hundreds of ducks during the summer months. The patients seem never to tire of watching these birds.

These things are of no little interest and pride to the citizens of the community, but how much more interest, pride and satisfaction are felt by those who have contributed to the cultivation of the fields and gardens?

It seems hardly necessary to emphasize the fact that the farm and garden vastly enrich the dietary of the patients and afford them foods which in point of freshness, quality and variety, could not be duplicated even if these vegetables could be bought as cheaply in the market, which of course is not possible.

Sweet corn, unless cooked and served the day

Doctor Creed can vouch for the dietary and economic value of state hospital farms with columns of statistics. He dwells also on two other values that are not so often emphasized—the esthetic and the therapeutic

it is pulled from the stalk has lost most of its sweetness, and is not palatable. The same is true of peas to a certain extent, and radishes are not tempting unless they are fresh and crisp.

Even if these articles of food were available in the necessary quantities in the markets how many states would provide the vast amount of money that they would cost? Unless other states are quite different from Ohio, patients simply could not get these important articles of diet, and would be served a winter diet the year around. As far as meats and eggs are concerned, no doubt the greater portion would be purchased anyway, though the freshness of the eggs, in that event, might be a little questionable. However, a hospital with a poultry house stocked with good hens, not only is assured that its eggs are fresh, but several times a year can provide a chicken dinner for the patients. If requisitions were sent in for chickens to serve patients, in all probability they would not often be approved.

All vegetables which are not consumed fresh are preserved by various methods such as canning, packing and drying, for winter consumption.

Because of drastic cuts in appropriations during recent years, the economic importance of the farm stands out prominently.

There are in Ohio twelve mental hygiene institutions of which seven are regular state hospitals caring for the mentally ill, one for the criminal insane, three for feeble-minded and one for epileptics exclusively.

Table I shows the amount of land owned or leased by each hospital, the acreage under cultivation, and the cash value of the various products raised in 1934, based upon prevailing market

TABLE I—FARM STATISTICS FOR YEAR ENDING DECEMBER 31, 1934

Institutions	Acreage Owned or Leased	Acres Cultivated	Fruits	Vegetables	Milk	Eggs	Slaughtered Products	Poultry and Game	Forage	Total
Athens.....	1,002	300	\$ 3,221	\$ 12,315	\$ 29,233	\$ 1,175	\$ 6,099	\$1,205	\$ 7,246	\$ 60,494
Cleveland.....	441	175	734	10,373	8,185	.....	4,867	.....	3,732	27,891
Columbus.....	304	145	1,536	16,177	.....	923	5,545	321	160	24,662
Dayton.....	1,155	983	5,113	22,469	32,905	903	10,153	365	18,588	90,496
Lima.....	751	500	1,513	8,421	15,704	2,321	4,659	785	7,131	40,534
Longview.....	299	160	94	4,862	.....	.....	5,859	.....	29	10,844
Massillon.....	1,645	1,135	7,559	34,981	40,246	3,963	13,196	2,194	19,959	122,098
Toledo.....	1,167	920	5,489	32,783	46,704	2,634	16,028	1,601	28,841	134,080
Gallipolis (Epileptic).....	671	293	1,732	17,474	5,346	42	3,579	24	2,914	31,111
Columbus (Feeble-minded).....	197	75	367	8,853	.....	.....	449	.....	.....	9,669
Orient (Feeble-minded).....	1,802	1,250	1,305	14,061	41,778	1,681	2,594	1,078	20,918	83,415
Apple Creek (Feeble-minded).....	1,930	1,128	311	9,056	.....	.....	2,334	332	17,188	29,221
Total.....	11,364	7,064	\$28,974	\$191,825	\$220,101	\$13,642	\$75,362	\$7,905	\$126,706	\$664,515

prices. The amount of land owned or leased by these twelve institutions was 11,364 acres, 7,064 of which were under cultivation during the year. The value of the various products was as follows: fruits, \$28,974; vegetables, \$191,825; milk, \$220,101; eggs, \$13,642; slaughtered products, \$75,362; poultry and game, \$7,905; forage, \$126,706, making a total of \$664,515.

This is no small item. But to understand these figures, it is necessary to know the cost of producing these food supplies. It is regrettable that this information is not available as far as the various items are concerned. The expenses are so overlapping that it is impossible for the individual institutions or the department of public welfare to keep accurate cost accounts on farm, garden and fruit crops. The meat slaughtered at the various institutions comes mainly from dairy animals and swine and the cost of production records on swine are difficult to keep because of the immense amount of garbage which hogs consume.

Milk production has cost from six to twelve cents a gallon at the various institutions. Had the same milk been purchased, it would have cost about twenty cents a gallon.

The poultry plants in the last few years, due to excessive mortality caused by range paralysis, have just about paid their way. It is felt, how-

ever, that as soon as control is established for this disease, these plants will show a nice profit.

From information obtained from the department of public welfare, it is estimated that the costs of production on the farms of the institutions under its control are from one-half to one-third the cost of the same items purchased on the open market.

The real purpose of a state hospital is the care and treatment of the mentally ill patients entrusted to it. They are entitled to every ethical therapeutic means which the hospital can provide.

It has been recognized for many years that occupation plays an important part in the successful treatment and management of the chronically ill and especially of those whose illness is mental.

While the term "occupational" has now a technical significance, work on the land, with flowers, poultry and animals is highly therapeutic. In his book, "Schizophrenia," Samuel W. Hamilton, M.D., Bloomingdale Hospital, White Plains, N. Y., says: "The patient who shows little interest or responsiveness to human approach may be gentle and happy in caring for dumb beasts." All of us who have had the opportunity to observe, know how true this is.

Probably no other occupation can equal employment on the farm and in the garden for health-

TABLE II—SHOWING AVERAGE DAILY POPULATION, AVERAGE NUMBER AND PERCENTAGE OF MALE PATIENTS EMPLOYED ON THE FARMS AND GARDENS

Institutions	Average Daily Population			Average Number of Men Patients So Employed	Percentage of Men Patients So Employed
	Male	Female	Total		
Athens.....	805	784	1,589	120	14.9
Cleveland.....	1,309	1,203	2,512	200	15.2
Columbus.....	1,448	1,405	2,853	109	7.5
Dayton.....	796	773	1,569	150	18.8
Lima.....	923	183	1,106	82	8.8
Longview.....	1,183	1,154	2,337	106	8.1
Massillon.....	1,493	1,369	2,862	305	20.4
Toledo.....	1,315	1,154	2,469	250	19.0
Gallipolis (Epileptic).....	1,142	999	2,141	130	11.3
Columbus (Feeble-minded).....	562	1,506	2,068	194	34.5
Orient (Feeble-minded).....	1,604	912	2,516	314	19.5
Apple Creek (Feeble-minded).....	247	189	436	66	26.7
All institutions.....	12,827	11,631	24,458	2,026	17.4

fulness. Not only are the sunshine, the fresh air and the proximity to nature conducive to physical health, but watching the little sprouts come up through the ground and seeing them grow to maturity, and realizing that they are doing something worth while stimulates in the patients interest, pleasure and pride in their work, which is conducive to mental health.

Tact and Patience Needed

In these respects there is no great difference between the mentally ill and ourselves, if the mentally ill individual is taught to realize that it is possible to derive pleasure from work as well as from play. To do this, however, often requires no little tact and patience on the part of the overseers. It is essential to use great care in selecting capable men with a thorough knowledge of farming to place in charge of these farms and garden workers. It would be folly to have as overseers men who know little of this type of work, as they could not command the respect of patients, many of whom know more or less about farm work.

Table II shows the daily average population of each of Ohio's mental hygiene institutions and the rather large number of male patients for whom the farms and gardens provide this healthful occupation. The number so employed is 2,026, which is 17.4 per cent of the combined male population. In addition most of these institutions use quite a few women patients during busy seasons to pick beans, peas, berries and small fruits. As a rule these women are eager to assist.

In an indirect manner the farms and gardens furnish occupation for many more women, who assist in preparing fruits and vegetables for immediate consumption or for canning.

The nineteen counties comprising the district from which the Athens State Hospital receives its patients contain no large cities. In fact it is probably more of a rural district than that of any other Ohio state hospital, so farming had been the previous occupation of a great many of the male patients admitted there.

It has been advocated by some that a patient after entering a hospital for the mentally ill should be engaged in something different from his previous employment and should not do the same kind of work that "drove him insane." Personally I do not believe that work alone ever "drove anyone insane." It would be futile and cruel to put them all at shop work even if the facilities at the hospital were adequate. Even if a different type of occupation is given at first, the patient is likely soon to ask for familiar work. We all know the force and value of work habits in ourselves. These

are of equal if not greater importance in our patients.

Not only has the employment of patients on the farm and in the garden been a great factor in creating and holding the interests of many, thus causing them to be more contented and preventing or retarding mental deterioration, but it has played an important part in leading to the recovery of many.

It is a common sight to see large groups of patients, even from disturbed wards, under the supervision of a few attendants, or possibly only one, working with hoes, shovels, scythes, axes and other tools and implements, with little or no discord.

Occupation in the open air is conducive to better and more normal sleep. These patients are ready to retire when bedtime arrives and not only are they directly benefited but by remaining quiet during the night they benefit other patients.

The exercise in the open air is also stimulating to the appetite, and the anticipation of consuming the products raised serves as an inducement to the patient, and in a small way as a reward for his efforts. The potted plants, cut flowers, and blooming shrubbery from the greenhouses and flower beds bring pleasure to bed-ridden patients which far more than compensates for the cost and trouble of growing them.

At Athens State Hospital we have never been provided with a trained occupational therapist. Consequently, we utilize the farm to good advantage along this line. Furthermore, the basic benefits of work in the open should be supplemented, not replaced, by other forms of occupational therapy.¹

¹To the superintendents of other mental hygiene institutions in Ohio and to John D. Bragg, chief agriculturist of the department of public welfare, for the figures and other information from their institutions, the author wishes to express thanks.

Planning for the "Extras"

Beware of the requisition for the purchase of equipment which may require additional expenditures after it is bought—expenditures not mentioned in the memorandum setting forth the need for the equipment and the justification for the expenditure. Dr. X asks for a piece of apparatus which costs several hundred dollars. After it is purchased the discovery is made that a few additional gadgets are needed, that a specialized employee must manage it, that it requires space especially set aside for its storage. It is embarrassing and sometimes humiliating for an administrator to inform the purchasing committee of his board of trustees that although he had himself endorsed the purchase, he had unwittingly misled them as to the final cost. The moral is, of course, to have every requisition for equipment carefully scrutinized from the standpoint of ultimate cost to the institution.—E. M. Bluestone, M.D., Montefiore Hospital, New York City.



Records Then and Now

THE shelves, stacks and filing cabinets in the record department of the New York Hospital, New York City, carry an almost unbroken series of records from 1793 to the present time. This material gives a panoramic picture of the evolution of record keeping for over a hundred years. The earliest document, covering the period from August 21, 1793, to March 25, 1799, is a large book of admissions with a heavy cardboard cover, its corners and back binding are in leather and its pages of a rough-surfaced heavy paper. It may well be thought of as the seed from which have grown modern methods of record keeping, with their innumerable divisions and subdivisions.

From the headings in this first record of patients admitted to the New York Hospital we see the basis of data required on admission of patients today. There are fourteen headings across the page: Number, Names of Pay Patients, Pays per Week, Securities Names for Pay Patients, Names of Pauper Patients, Occupation, Age, When Admitted, Names of Visiting Committee by Whose Orders Patients Were Admitted, Physicians or Surgeons, Diseases, Time Discharged: in what State and on what Account, Died, Remarks.

In February, 1797, we notice the insertion in ink of a column headed, "Where Born," and the birthplaces subsequently recorded include America, England, Holland, Ireland and Portugal. Because of the number of mariners among the patients admitted, birthplaces were as varied as they are today.

In the first column headed "Number," which is such an important factor in modern record keep-

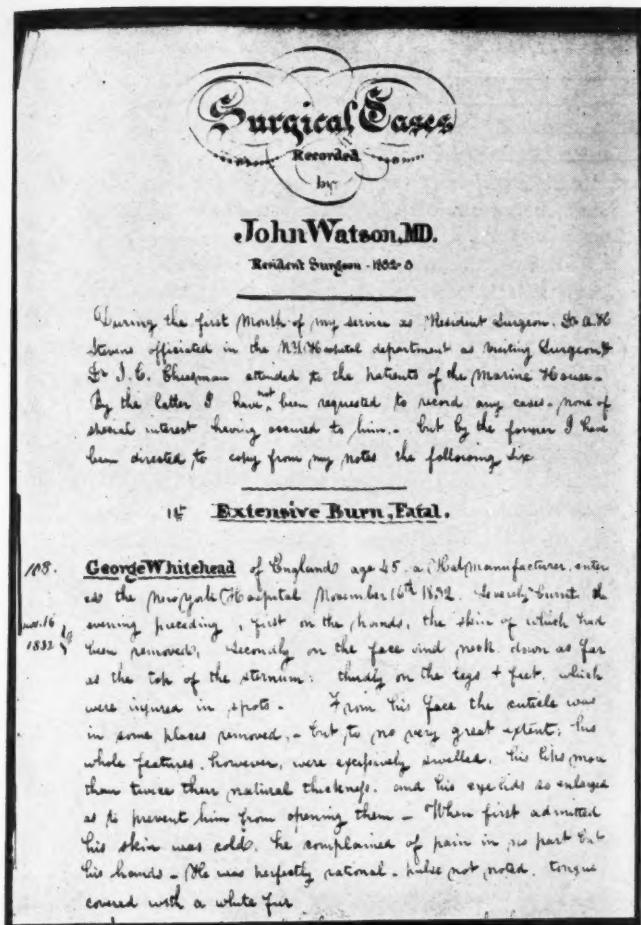
By HELEN B. LINCOLN, B.A.

ing, we notice a logical scheme of numbering as the patient's admission is recorded. These numbers run in one series for a period of almost two years. There is then a break in the series with the admission of the last patient on January 30, 1795. From this date on, a series ends at the close of January and a new series starts the first of February each year through February, 1799. Perhaps this is an early step in medical accounting so that the number of patients per year could be determined easily.

Speaking of accounting, our modern financial accounting departments would scan with interest the almost blank column of pay patients and the very full list of pauper patients. Pay per week seems to run twelve to thirty-six shillings, the most common rate being 16/s and 24/s. The high of 36/s was paid in July, 1797—a possible wave of prosperity!

Most of the patients range in age from sixteen to forty. There are few children and few people over sixty. There are seventeen patients twelve years old or under; seventeen patients aged sixty; two patients aged seventy, and one patient aged eighty. There is one child aged twelve whose occupation is given as servant, a pay patient, apparently paid for by his employer.

The following are typical diseases listed: syphilis, gonorrhea, catarrh, frozen feet, sore eyes, pneumonia, fracture, cancer, dropsy, palsy, gravel. A remarkable number were discharged



Page from the volume of the first real histories at New York Hospital, the "surgical register of interesting cases, 1808-1833." The book, of tooled leather, is shown in the center on the opposite page.

"cured"; others "relieved," "incurable," "by desire" or "eloped."

A list of occupations taken from this early register sounds like the famous nursery jingle, "Rich man, poor man." While the majority of occupations given are mariner, laborer and spinster, there are others given which call up a colorful picture of the life of the period:

- | | |
|---------------|----------------|
| Tanner | Nail Maker |
| Blacksmith | Rigger |
| Starch Maker | Coach Maker |
| Cabinet Maker | Coach Driver |
| Weaver | Servant |
| Stone Cutter | Gent |
| Peddler | Farmer |
| Rope Maker | Indian |
| Washer | French Invalid |

The space left for "remarks" is almost always blank, so that the name of the disease and the condition on discharge are all we find in the nature of a medical record of the case at this period.

The first real histories at New York Hospital are a group of selected and unusual surgical cases

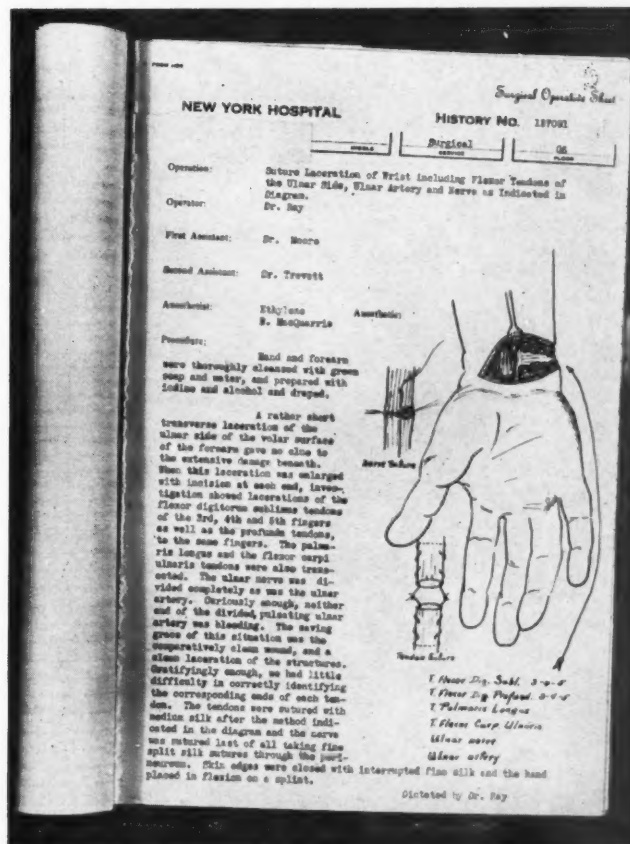
recorded in a tooled leather volume, dated 1808-1833, entitled "Surgical Register." This volume contains narrative accounts of "interesting and important cases, selected from among the surgical patients."

The house staff may have kept full "pocket notes" on all cases but made permanent record of a few selected cases only, as the following quotation taken from one of its pages might suggest:

"During the first month of my service as Resident Surgeon, Dr. A. H. Stevens officiated in the New York Hospital Department as Visiting Surgeon and Dr. I. C. Cheesman attended to the patients of the Marine House. By the latter I have not been requested to record any cases—none of interest having occurred to him—but by the former I have been directed to copy from my notes the following six."

Some of the pages of this book are beautiful examples of shaded handwriting. Each case is numbered, carries the diagnosis of the case in large shaded capital letters at the head of the page. The identifying data are scant, the following being typical:

"Christian Schultz a Dane aged thirty-two has been a patient of the House for nine weeks, having entered for a Rheumatic complaint of which



Page of unit history, New York Hospital, 1936, bound in flexible manila folder; with the typewritten operative report is a diagram of procedure.

after use of various other means he was at length relieved by the Vapour Bath."

"John Bennett, a farmer aged fifty-one, a native and resident of New Jersey entered the New York Hospital November 9, 1831, with gangrene of all the small toes of his right foot and one of the middle toes of the left."

"James Hall, aged twenty, born in Connecticut, entered the Hospital November 5, 1831, for the purpose of undergoing an operation for the cure of a disease of which the following is the history."

There is a good narrative history but no physical examination other than that of the diseased or injured part. There are treatment notes, including medication given, progress notes, the condition on discharge and the signature of the attending surgeon. Most of the cases have a very full account of the operative procedure, and we find a few postmortem or dissection notes.

New York Hospital has been called the cradle of surgical development and teaching in America, and in the context of this very early volume there are notes and comments showing the ever present spirit of contribution to medical and surgical development. Just as we find in our records at New York Hospital today quotations from medical literature in connection with rare cases, and drawings depicting interesting surgical technique, so in this volume of 1808 we find a quotation from "Hennan's Military Surgery, case 29, page 171."

Also of interest is a list of pulses taken at New York Hospital during the prevalence of the cholera epidemic in 1832 to determine whether the pulses of patients were quicker during the epidemic than during the ordinary seasons. The result, however, showed that the pulses were unaffected in any material point.

Companion Pieces

As companion pieces to this early surgical register we have a similar "Medical Register," dated 1809-1834, and a long narrow volume dated 1809-1825, a record of the lying-in ward of New York Hospital, the full title of which is "Book of Record of Entry and Delivery, Single and Double," with the following heading on the first page, "A list of patients admitted and delivered in the Lying-In Ward of the New York Hospital commencing anno domini 1809."

The headings in this latter volume, stretching from left to right across the two pages of the book, include: Number, Patients' Names, Recommended By, Age, Admitted, Delivered, By Whom Attended, Presentation, Number and Sex, Their State, Children's Names, Discharged, How, Remarks.

In November 28, 1810, the heading "Vacci-

nated" was added, and in October 26, 1816, the headings "Number of Hours in Labor" and "Number of Previous Children." It is interesting to note that labor is recorded from one minute to ninety-six hours.

The following is an excerpt from the case book dated 1840-1841 which apparently marks the beginning of permanently kept records on all patients admitted to the hospital instead of on a few selected cases:

DIRECTIONS TO SENIOR WALKER

"According to the By-laws of the New York Hospital it is the duty of the senior walker to keep a record of all the cases in that department of the House to which he is attached. In order that this duty may be properly performed, it is requisite that the history of every case should be entered in the case book on the day in which the case terminates and the patient is discharged. The entry of the cases will therefore be in the order of the discharges.

"As *auxillaries to the case book* the senior walker must have the following:

"1. A register ruled in a tabular form in which he enters: *when the patients are admitted*, the date of their admission, the ward into which they are received, their names, ages, places of birth, occupations and diseases; and when they are discharged—their condition when they leave the house, the date of discharge, and the number of their case as entered in the case book.

"2. A *Memorandum Book* in which the particulars of each case are taken up to the time at which the patient is received; and in which minutes are to be entered as to the treatment and progress of the case, while in the hospital.

"3. A *Discharge Book* in which the name of each patient should be entered on the day of his discharge stating his condition, what ward he left and how long he had been in the house. From this book the cases are next to be discharged from the Register and in the order of their discharge they are to be recorded in the case book. A blank column is to be left in this book in which the attending surgeon should place the initials of his name as a voucher to the Board of Governors that each case has been posted into the register and properly written up in the case book."

From this date, 1840 to 1847, the case books used were somewhat smaller than the first registers. However, with 1847 the larger volume was reverted to, and as we go on the volumes become thicker and heavier so that in 1890 we have a mammoth book 14½ inches high and 5 inches thick and in 1896 a volume 7 inches thick.

Inventions, new technique and medications, all

have had their influence on record forms. Urine and opium tables were written into the treatment notes in 1866, but in May, 1867, we find a "Urine Record" sheet inserted with the following headings: "Date, Ounce, Specific Gravity, Pulse, Weight of Body, Amount Fluid Drunk." We also find a table headed, "Pulse, Respiration, Remarks," under treatment notes in September, 1864. With the invention of the thermometer temperature recordings were drawn into the record under the heading: "Record of Vital Signs," the first appearing in February, 1866. In August of that year we find our first special "Temperature, Pulse and Respiration" sheet.

The earliest attempt at indexing appears in 1862 where a section at the back of the volume has been marked off alphabetically and the diagnosis of a case entered under its initial letter giving the page on which such a case is to be found.

By 1877 we find that the volumes contain a name index as well as a diagnostic index, the former now at the back of the volume and the

latter at the front. The names were not entered in a strictly alphabetical manner but according to initial letter only.

The first evidence of recording the family history of the patient appears in 1879, with such entries as "Inheritance good," "Mother died of Phthisis." A forecast of the physical examination as we know it is the examination of the heart which occurs frequently in the records of 1882. By 1886 we find family history and physical examination appearing as a matter of routine, quite full and with marginal headings.

The so-called history number as we know it made its appearance January 1, 1898. With this volume we have records bound according to "History Number" which was apparently the admission number. With case Number 1, January 1, 1898, we also have a 3 by 5-inch alphabetical card index, which covers the cases from this date to June, 1914, and case number 195,165. The private patients' records were separated into volumes labeled "Private Patients," November, 1913.

Number.	Names of Pay Patients.	Pay per Week.	Securities Names for Pay Patients.	Names of Pauper Patients.	Occupation.	Age.	When admitted.	Names of the visiting Committee, by whose Order Patients were admitted.	Physicians, or Surgeons.	Diagnosis.	Time discharged—In what State, and on what Account.			Died.	REMARKS.
											Month.	Day.	State.			Month.	Day.
291	Matt. Walker	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
292				Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
293				Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
294				Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
295	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
296	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
297	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
298	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
299	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
300	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
1	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
2	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
3	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
4	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
5	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
6	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
7	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
8	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
9	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
10	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
11	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
12	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
13	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
14	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
15	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
16	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
17	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
18	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
19	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
20	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
21	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
22	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
23	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
24	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
25	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
26	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
27	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
28	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
29	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
30	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21
31	Ed. Conner	10s	Wm. Conly	Ed. Conner	Blacksmith	21	21	W. Tinsale	D. Bard	Supplies				21	21

Page from the earliest record; register of patients admitted to New York Hospital, 1793-1799.

These were continued, bound according to admission or history number, until the month of December 29, 1923.

From 1898 on, special printed sheets took the place of the former method of writing notes into the record book. There is the sheet for identifying data, for history and for physical examination; a special sheet for medication, treatment and progress notes; the temperature, pulse and respiration sheet, and the laboratory sheet. Again inventions and the progress of science have added other special sheets to the patient's record—the roentgenologic report, specimen reports and electrocardiographic reports.

In 1914 the Bellevue System of Diagnostic Nomenclature was adopted with case records bound in volumes according to diagnosis. With this date we enter upon contemporary history in record keeping.

Record Becomes Complex

During a twenty-year period there evolved a complexity of detail in the recording of data—alphabetical name indexes, cross references on diagnoses and statistical studies. The patient's record became a detailed history of every step of his care while in the hospital. Single special sheets were used for recording the various phases of the case. On discharge of the patient the parts of his record were edited for required data, arranged according to a set order, and finally prepared for binding into a volume under its diagnostic classification.

Volumes bound according to diagnosis are most helpful in study and research, but there are difficulties in their use in connection with the treatment of the patient. Volumes are heavy and bulky to send to the ward on readmission of the patient. A request for one record means the sending out of some fifty others. Binding by diagnosis also means that there may be two, three or more records of the same patient, located in two, three or more volumes in different parts of the room. There is also the chance of two calls for the same volume for patients readmitted to different services.

The growing importance of records for research, for medico-legal and other uses and for the treatment of the patient, has encouraged methods of record keeping which will serve adequately all these purposes. Meeting these needs has marked another milestone in the evolution of record keeping, and the modern record department is characterized by a trend toward modern business methods.

With the opening of the new building in September, 1932, the unit system was adopted. This

system provides that all data pertaining to one patient be filed together. A history number is assigned to the patient on his first contact, and all subsequent history is recorded in one folder under his history number, regardless of the number of times he is admitted and regardless of the number of different departments he may have contacted. All data—in-patient, out-patient, social service and correspondence—are assembled in one folder giving the whole picture of the patient's course in his connection with this institution.

There have been installed the modern types of coded name, diagnostic and operation indexes for cross reference to the case record; there are punch card studies, steel filing cabinets and modern methods of binding. The extensive use of the medical record has not only influenced its content but also its physical make-up. The records are bound into flexible manila folders as it must be possible to transport them rapidly to far corners of the building via the pneumatic tube system. Both folder and stock of history sheets are thin but tough, as the records must stand hard usage, must be readily accessible, require a minimum of filing space and must be permanent.

I venture to say that we have reached the saturation point in complex detail in record keeping and that our next important step will be simplification of systems and working routines to produce the maximum in essential data with the minimum of labor.

Earning Pin Money

Institutions like individuals found in many instances that the depression was not an unmixed evil. Necessity prompted the adoption of new methods and new ideas and frequently the results were surprisingly happy and efficient. Expenses were cut when possible but sources of new income also were scanned.

In one hospital the "lay off" of laundry employees was avoided by contracting for the laundry work of an orphanage and a convalescent home, each of which was not large enough in itself to afford or warrant the expense of having its own mechanical laundry equipment. The same hospital, at Christmas time each year, through its dietary department and coffee shop sells to its own community of friends and personnel from one to two tons of fruit cake and the profit is used to purchase for the dietary department equipment that might otherwise be considered extraordinary if charged to operating expense.

Another large hospital manufactures in its pharmacy and sells within the hospital a distinctive and neatly packaged line of the commoner drug store commodities. In both instances the criticism and antagonism of commercial houses have been avoided by the frank assertion that when the deficit of a charitable institution is decreased, more charity is available for the indigent. — *Basil C. MacLean, M.D., Director, Strong Memorial Hospital, Rochester, N. Y.*

Going the Second Mile

Compiled by
MRS. FLORENCE R. SIMONS

Three Persons Rate the Hostess

FOR two years I have served as hostess of Emory University Hospital, Atlanta, Ga. Mine has been pioneer work. Duties were not defined in advance; they grew. There were those among the doctors who questioned the advisability of "a lady puttering about" their patients. Not all the hospital personnel were cordial to the idea, but gradually the office became accepted and now seems to have justified its creation.

It was suggested that appraisals of the hostess's work from those who had seen it in this hospital might be of help to others. Accordingly, there are presented here three viewpoints: that of the administrator, by Robert Hudgens, assistant superintendent; that of a patient, by Mrs. M. M. McCrary; that of a staff member, by Dr. Frank K. Boland, visiting surgeon.

Seen by the Administrator

Two years ago we had a good hospital machine. It was respected, even admired but too little loved. We still have the machine but we have added to it humane qualities. Now we know we have a better hospital.

The turning point was the creation of the office of hostess. This provided an approach to an intangible situation. We soon proved what we had suspected—that it was the aggregate of relatively unimportant services which impressed patients and their friends. Ligatures of certain quality and assured sterility were less appreciated than the cup of coffee voluntarily served to a relative awaiting in the alcove the outcome of an operation. Costly anesthesia machines, safeguarded against explosion hazards, went unnoticed and unappreciated whereas a telephone call too trivial "to bother the nurse with" but suggested and made by the hostess, became the essence of true service.

Lay people judge a hospital none too accurately on its scientific excellence. They either presume that an apparatus functions properly and that medications and treatments are competently administered or they have too little knowledge of these things to judge them. But how accurately and quickly they sense the spirit of an institution, and estimate its degree of hospitality! If the atmosphere is cold, the word soon spreads and the rest of the administrator is troubled. People normally seek a personalized service if they have any choice, whether it be in a church, a hotel or a hospital.

It is the duty of the hostess, then, to concentrate time, thought and talent upon this fact. She holds no monopoly upon acts of graciousness. She cannot be effective alone but she must be protected against the encroachment of routine, or pressing tasks which limit her freedom. Hers is the rôle of an opportunist. She works neither by chart nor by clock but by the exigencies of the moment. There are, of course, many things which she does again and again each day but they are not necessarily ends in themselves. They are avenues of approach which may become blind alleys, as they often do, but the hostess explores them and frequently finds that they open new possibilities for service.

Arranging a vase of flowers, delivering an impatiently awaited letter, telegram, newspaper or message, offering books and magazines, or just dropping in appropriately—these are the approaches. The ultimate service may be anything and turns out to be everything. For one person the hostess runs into town to do a bit of shopping; for another she orders cigarettes or summons a notary; for another she telephones the maid to dictate a weekend grocery list. One patient may welcome a spiritual adviser; another may desire only a target at which to shoot some caustic comment; this patient the hostess accompanies to the train; for this one she writes a letter; with one who is lonely she just sits and talks; another she carefully avoids and cautions others to do like-

wise. In addition, there is the desk work. To many patients she sends follow-up notes. She is supplied with special stationery for the purpose.

Listing these duties suggests an important point—the qualifications of the hostess herself. She must have an intuitive sense of the appropriateness of things. She must be all things to all persons, the right thing to the specific patient. She cannot get this from books or coaching, though they are helpful. Some patients like flutter and bother; others are annoyed by it. Some are to be cheered; others calmed. One doctor wants his patients visited frequently; another prefers that visitors stay away. These things the hostess must know, not by too much trial and error but by a sort of divination.

Her duties are not to be confused with those of an information clerk. If she does any lobby work at all, she must avoid the odious transparency of the professional greeter. She must be pleasantly discovered at the right time by those who have need of her. A sizable order! Yes, but one that can be filled to the reasonable satisfaction of all.

One might reason that the duties herein ascribed to the hostess should be the charge of the entire personnel, and so they should. She does not preempt the field any more than the housekeeper destroys dirt consciousness or the superintendent, by his surveillance, interrupts economy of operation. Rather, like these, she draws attention, by precept and example, to the realm over which she presides. She alone of the hospital personnel has no other duty to divert her attention from the little things that loom large.

Thinking of the hospital as necessarily a business as well as a service, I should say that next in importance to success in the care of the patient comes the popularity of the hospital with its patients. It is a costly failure on the part of the hospital when the outgoing patient can say in effect: "Apparently everything was done properly. I was neither misused nor neglected. I suppose I got all that was coming to me, but I just don't like you."

The hostess personifies the extra mile—the voluntary service which does not appear on the bill. By what she herself does and by what she leads others to do, the hostess keeps alive the personal and human qualities which can so easily and unintentionally become neglected. She picks up slants which nurses' thermometers do not record and sounds not heard through the stethoscope. A finer hospital results. The personnel catches something of her spirit, the superintendent is pleased when his institution is complimented for its hospitality, and doctors enjoy treating satisfied patients.

Seen by a Doctor

The work of the hostess at Emory University Hospital for the past two years has been a valuable asset to the institution.

To fill a position of this kind satisfactorily requires certain qualities and talents developed to an extraordinary degree. First, the hostess must be blessed with good health. Without this, no woman no matter how willing could generate the energy needed to carry her up and down, in and out of the hospital as many times a day as her work requires. The poetical picture of the "lady with the lamp" wandering among sick and wounded soldiers is beautiful and impressive, but in our hostess we have a figure just as kindly.

Initiative is another important quality required in a hospital hostess. What does she do? She makes endless rounds over the hospital seeing that patients receive their mail and flowers and messages, and also that patients' mail and messages leave the hospital. She also takes upon herself the responsibility of providing patients with ample reading material.

Naturally the hostess gives more of her attention to patients who are away from their home towns or who do not appear to receive much outside attention. There is little for her to do among those who are constantly showered with presents and visited by friends. But what a service she could render the doctor and the patient in such cases if she could curtail the number of visitors and the length of their visits!

Probably no characteristic in a hostess is more necessary than tact. Almost as necessary is a pleasant personality. Then come education and a broad knowledge of affairs, past and present. Thus equipped, the hostess is able to chat with all classes of patients on a variety of subjects.

Seen by a Patient

Ten months as a patient at Emory University Hospital have convinced me of the necessity of a hospital hostess.

Each day I looked with keen pleasure for her appearance with the mail and a bit of news about this or that. Her cheerful attitude gave the patients confidence to ask necessary favors. Since she touched the daily life of all patients, she was busy indeed, but never too busy to give attention to the humblest patient.

Emory University Hospital would be a dreary place without the hostess. I should not like to imagine my ten months of confinement there without her daily encouragement.

A Community Charge—the Chronic

New York—state and city—is awake to problems of chronic illness. More than that, it has taken steps to provide the care needed for the individual case. Mr. Ford summarizes present and suggests future activities

By CLARENCE E. FORD

IN NEW YORK State as elsewhere the essentials of a community program for the care of chronic illness are: adequate institutions with sufficient clinic facilities; home relief with suitable supervision and assistance; skilled medical attendance. Studies indicate that these facilities will be required for about 1 per cent of the population in addition to the provision for mental illness and tuberculosis which are sometimes chronic diseases.

For consideration of matters relating to chronic illness, the State of New York may properly be divided into three areas—the metropolitan area including New York City and its immediate suburbs; the populous counties containing large cities such as Buffalo and Rochester, and the rural sections.

The metropolitan area is fortunate in having had the studies of Mary Jarrett, the counsel of Dr. Ernst P. Boas and Doctor Cohn, and the organizing genius of Dr. S. S. Goldwater, commissioner of hospitals. In New York City, too, there is considerable provision in private institutions for the care of chronic illness, while outside of this city there are only two small institutions carried on for this purpose. However, it is not so much what has yet been accomplished as that New York City alone among the communities of the state, has had sufficient investigation to find out just what the situation is and enterprise enough to formulate a long term plan.

Those who have to do with appropriations by public bodies know how difficult it is to obtain money for research not directly involving the care of inmates. Doctor Goldwater has been able to obtain a modest appropriation for this purpose

and a research laboratory for chronic diseases is now in operation at Metropolitan Hospital. So far as I know, it is the first important research activity for chronic diseases to be inaugurated by a public department.

In speaking of these facilities in New York City, I wish to take the opportunity to emphasize the need for medical research in all communities which provide treatment for chronic diseases. While something has been accomplished by way of progress in treatment, such progress has been meager as compared with the advancement in the prevention and treatment of the acute infections, especially those of childhood. I need only mention the increasing death rates from diabetes and cancer as illustrations.

Moreover, it should be emphasized that no institution is too small to do some research work. Last year much attention was given to the fiftieth anniversary of the discovery of the bacillus of tuberculosis by Dr. Robert Koch. During the early part of his career, this master of medical bacteriology practiced as a country doctor with crude laboratory equipment, much of it homemade. Who knows but one of our small institutions may find a remedy for, let us say, arthritis.

In addition to research, the department of hospitals of the city has developed plans for and is about to erect a modern hospital for the chronically ill, with some 1,500 beds. This provision, when available, will go a long way towards relieving the situation in New York City.

What WPA Project Provides

Reference should also be made to the demonstration and study of home care of chronic patients recently inaugurated by the WPA in New York City with the cooperation and advice of Miss Jarrett and her committee. The announcement of this project states that it provides the following:

"1. An experiment in home nursing care of chronic patients by a nursing organization with the aid of visiting housekeeping aids.

"2. An experiment in housekeeping service for

chronic patients who do not require nursing care.

"3. An analysis of these experiments by physicians who have had experience in the field of chronic diseases.

"4. Setting up a method for observing and recording current experience in nursing and house-keeping services for chronic patients.

"A further aim of the project is to determine to what extent it is better for the patient and cheaper for the city to care for dependents chronically ill in their homes or in institutions."

Now let us note for a moment the situation in the second of our subdivisions of the state, the populous counties. The public homes in almost all of these counties have fairly modern facilities for the care of chronic illnesses but the constant complaint is that such institutions are overcrowded and desired admissions cannot be secured. All these communities provide home care for chronics as well as for others and the various nursing homes, now so frequently found, often receive chronic patients on commitment by public authorities.

More Specialized Medical Care Needed

Outside of New York none of the institutions for chronic patients, so far as I know, maintains the out-patient clinic service which is so helpful especially for discharged patients. In general, it may be said that so far as these populous counties are concerned, the facilities are available though not always in sufficient amount. What is especially needed is better specialized medical service for chronic patients.

When we look at the rural counties, especially those of small population, the outlook is anything but hopeful. For years the state department of social welfare has been endeavoring to secure the construction of adequate infirmaries connected with public homes, which infirmaries would be designed primarily for chronic cases. This effort has been attended with considerable success in larger counties but with little result in smaller ones. Many of them have too few inmates and the counties are, or at least believe themselves to be, too poor to provide an adequate infirmary for chronic patients.

What then can be done? In finding the answer, we should, I think, copy the action which has been taken with reference to the care and treatment of a disease which is sometimes chronic, namely, tuberculosis. To serve the smaller counties not provided with their own hospitals, the state department of health has constructed three district hospitals in which care is provided by the state but a certain proportion of the cost charged back to the county in which the patient resides. Can

we not follow the same plan for chronic illness? I think we can, and I look forward to the time when there will be sufficient district hospitals well constructed and efficiently administered, available to the residents of less populous counties.

In passing, I wish to refer to the provisions of the new Old Age Assistance Act as it may materially affect the care of chronic patients. The original law forbade the granting of these so-called old age pensions to any who were inmates of institutions except that temporary care might be provided in a hospital. The new law follows the federal statute in lowering the minimum age limit to sixty-five years and in providing that payment may be made for care in a private home for the aged.

According to a census taken by the state department of social welfare as of February 29, 1936, there were, in private homes for the aged in this state, 14,708 beds—a very considerable number and approximately equal to the number of beds in all of the county and city public homes. Payments to private homes for the aged have not yet begun and it is too early to predict what the effect of such payment may be. I hazard the guess, however, that with the increased income available, private homes for the aged will be more willing to admit persons with chronic conditions when such persons are eligible for old age assistance.¹

¹Read at the New York State Conference of Social Work, Rochester.

Dramatic Savings

A ruler once wildly exclaimed, "My kingdom for a horse" and would thus have established a scale of values that might have been justified in those days of one-sided barter if it had not been for the restraining hand of poetic license. This rhetorical bargain would hardly win the approval of bankers and economists of our day, unless they were on the profitable end of the transaction.

To make a long story short, there are a number of dramatic possibilities for realizing huge returns on minute investments in a manner that accords strictly with hospital ethics and which would command universal approval. Take, for example, the proper cleansing and oiling of the various needles that are used for puncture in the human body. A tiny droplet of oil properly applied to a lumbar puncture needle may be the only safety factor between a routinely successful tap and an infection with disastrous and even tragic consequences.

If such needles are not carefully cleaned and oiled after use they will rust in the cannula with the formation of rings of weakness which are not apparent to the eye on the most careful examination. Consider the physical discomfort caused by the use of such needles and the terrifying possibilities when they break at the wrong time. A small investment will indeed guarantee ample returns, even though these returns have preventive value only.—*Morris Hinenburg, M.D., director, Jewish Hospital, Brooklyn, New York.*



Deaconess Hospital at Neumünster, near Zurich.

Alpine Hospitalization

By WILLIAM A. RILEY

ON a recent trip to Switzerland I had the opportunity of studying some interesting aspects of Swiss hospital architecture in Zurich, Berne, Basle and Lucerne. Many excellent modern hospitals have been built during the last few years.

The Children's Hospital or *kinderspital* in the suburbs of Zurich is a 300-bed clinical institution with a recently built pavilion for infectious diseases. This is the only children's fever hospital in Zurich. Tuberculosis cases are cared for on the fourth and top floor where there is ample space for open air treatment. Wards are not over three-bed capacity and all have a southerly exposure.

This hospital is typical of the newer Swiss institutions in respect to architectural design. The construction is of reinforced concrete with ivory colored exteriors; large, horizontal type windows, and wide balconies overlooking lovely gardens and lawns.

Interiors are equipped with modernistic metal furniture. Planning and detail are well thought out and there is a considerable amount of built-in equipment. Glazed partitions separate the wards throughout, thereby affording ample light and

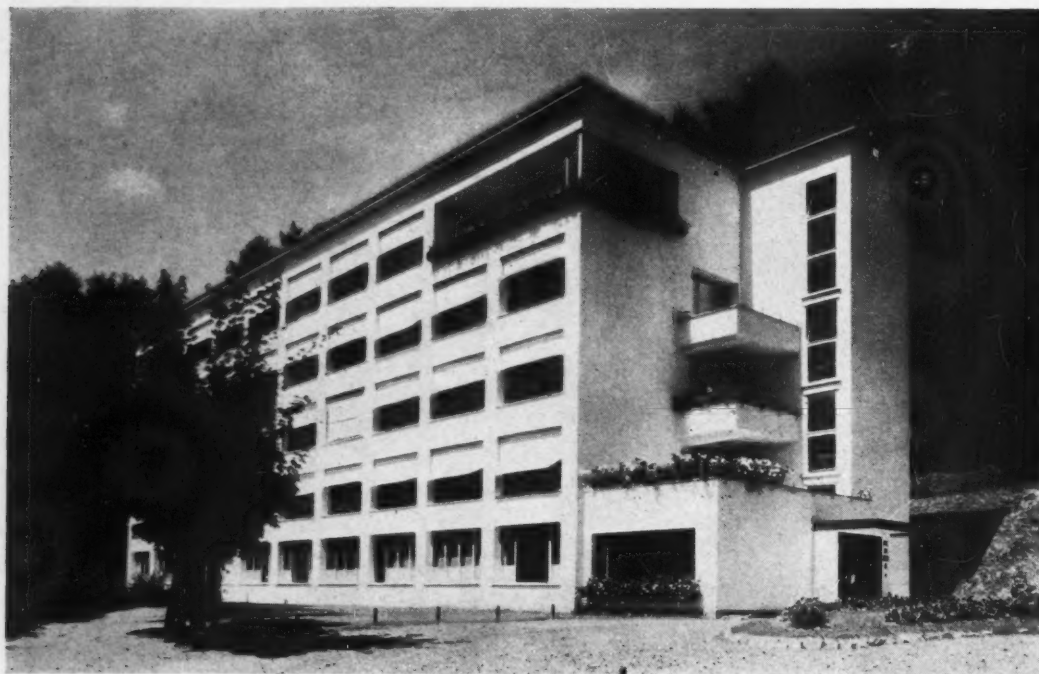
Built for sun and air are the hospitals of Switzerland, utilizing the finest in design — large windows, wide balconies, color and space

simplifying surveillance of the children. Walls in many rooms are covered with a washable wall paper which is said to be more economical in upkeep than painted surfaces.

Another unusual and well planned hospital is the Deaconess Hospital at Neumünster, near Zurich. This is an L-shaped general hospital of about 300 beds, constructed in 1933 at a cost of over \$2,500,000.

The administration, medical, surgical and operating departments, as well as the nurses' quarters, with chapel adjoining, are in one continuous four-story building. The medical and surgical sections of the hospital use the same operating rooms, x-ray equipment, pharmacy and laboratories.

In each ward are only four beds, arranged par-



The Cantonal Hospital at Lucerne has two pavilions—a surgical and a medical, each of 100-bed capacity. Above, an exterior view of the surgical unit; left, a view of the waiting room.

allel to each other. No wards are larger. This is done to facilitate the grouping of patients into various stages of illness. Here again all patients' rooms are on the south while utilities are placed opposite on the north side.

Interiors are void of all unnecessary architectural detail. This severeness is relieved through the use of colored wall treatment as well as by the many plants and flowers which are in solariums, sitting rooms, corridors and patients' rooms. Built-in equipment such as counter top, black-board trim and cabinets are of monel metal.

Nestling in the Alps at Elfenau, near Berne, is a new and practical little hospital, known as the Berne District Infant and Maternity Home. Although a small voluntary institution of about 100 beds, it is worthy of inspection. This hospital caters to the dietetic ailments of small children and also accommodates mothers who may convalesce after confinement.

The children's department consists of a series of six-bed wards. The partitions separating these wards and corridors are glazed from bed height

to the height of the doors. Each child's crib has a small tray for such necessities as brushes, thermometer and nail scissors, attached at its foot.

Each baby has an individual wheeled cot into which he is transferred from his stationary bed and transported on to the long airing balconies. At night these cots are stored in the large glazed solariums at either end of the balconies. Each ward has built-in linen cupboards which are accessible from the corridor as well as from the rooms.

The light colored concrete terraces, stretching horizontally the full length of the building, with the bands of blue colored window frames and the flat roofs intended for light, air and sun bathing, betray the purpose for which the building was designed. The interior, with its playrooms and nurseries is just as interesting.

The Cantonal Hospital at Lucerne, a state maintained hospital, has two new pavilions, one a medical and the other a surgical unit, each of 100-bed capacity.

Chief characteristics of these new departments are their simplicity of construction, application of color and large windows. The steel windows extend the full width of private rooms and are so constructed that they can be raised to a horizontal position at the ceiling, thus allowing full ventilation and a splendid view of the Alps. One must not overlook the fact that such windows are possible in countries that require no insect screens.

Sixty Improvements in Hospital Care

*Based on data gathered by a survey staff
under the direction of Dr. Haven Emerson*

UNDER the chairmanship of Dr. George E. Vincent a committee of 100 distinguished citizens of the New York metropolitan area has been engaged for two years in the first comprehensive study of the activities, investment and financial operations of all institutions and agencies organized for the care of the sick in that area. Data were gathered by a survey staff under the direction of Dr. Haven Emerson. Herewith are presented the recommendations. Copies of the full reports, published last month, may be obtained from the United Hospital Fund, New York City.

Hospitals

1. That a permanent, representative and authoritative planning group in New York City, and similarly in other large subdivisions of the New York metropolitan area, representing or conversant with all appropriate functional and regional interests, review and pass upon all proposals for major capital expenditures in the interest of organized care of the sick, especially those for increasing the bed capacity of voluntary, municipal and county hospitals.

2. That the dual system of providing general care for the sick poor, both in hospitals directly operated by the government and as public charges in voluntary hospitals paid for by tax funds on the basis of service rendered, be continued.

That the use of voluntary hospitals for the care of public charges be developed as far as possible.

3. That hospital facilities for the general care of the sick poor be substantially increased by any or all of the methods suggested below until the average occupancy of government hospitals does not exceed approximately 85 per cent of their normal bed capacity: (a) The use for ward service of some of the facilities now assigned to private service in voluntary hospitals that care for public charges; (b) The use for public charges of more of the properly equipped and suitably organized voluntary hospitals; (c) Increase of the bed ca-

capacity of the municipal hospitals in New York City and of the municipal and county hospitals in the metropolitan area outside.

4. That organized medical care of the sick in their homes as an extension of hospital out-patient service be developed as rapidly as possible to the fullest useful extent, in order to obviate unnecessary capital expenditures for the increase of municipal and county hospital facilities.

5. That the number of beds for private patients in voluntary hospitals in the New York metropolitan area be not increased without the approval of the authoritative planning group, but that when an institution can demonstrate its need for additional facilities for semiprivate patients, these be increased preferably by the use of beds now assigned to private service.

6. That the authorities of such of the larger general hospitals as now exclude patients with mental disease, tuberculosis and other chronic conditions, and patients with syphilis and gonorrhea in the communicable stage, seriously consider revision of this policy.

That at least some of the larger general hospitals, which now have or later appoint appropriate specialists on their medical staffs, provide for the temporary care of patients with these conditions.

7. That no more general hospitals of less than 200-bed capacity be built in New York City, or, except in unusual circumstances, in the metropolitan area outside New York City; and that there be no capital expenditure for reconstruction of small hospitals not now used to advantage by the community.

That the number of relatively unoccupied general hospitals of smaller size be gradually decreased, through merger with larger institutions.

8. That the number of relatively unoccupied special hospitals, except those for tuberculosis, acute communicable diseases and mental diseases be gradually decreased through merger with general hospitals.

9. That any application of a proprietary hospital for incorporation as a voluntary hospital, primarily to avoid payment of taxes, be actively opposed.

That no opposition be offered to legitimate plans prompted by motives of public service for the conversion to voluntary status of a hospital plant which is suitable for use as a voluntary institution affording free service to the poor.

10. That unless there is need in the entire community for more hospitals, no hospital be constructed merely for the purpose of serving a particular locality or neighborhood; but that as new hospitals are needed, the desirability be considered of locating them in areas which now have relatively few hospital beds.

11. That hospital authorities collaborate with their medical staffs in considering ways and means of providing remuneration to the medical profession for service to the indigent.

12. That all general hospitals organize their professional staffs for the further training of physicians in practice and the education of interns and residents in such manner as to make them eligible to become approved teaching units.

Nursing Service in Hospitals

13. That in general hospitals serving largely acutely ill patients, the average number of hours of bedside nursing care in the twenty-four-hour period be at least those provided by the typical or median group of voluntary hospitals, namely, 2.5 hours for medical patients, 2.4 hours for surgical patients, 3.1 hours for maternity patients, 2.3 hours for newborn infants, 3.0 hours for pediatric patients.

14. That the duties of all nonprofessional workers—attendants, orderlies and ward helpers—be limited to the functions which they are qualified to perform.

Out-Patient Services

15. That general dispensaries organized both administratively and professionally as units of voluntary and municipal government general hospitals, or branches of these appropriately located in relation to transportation facilities and to population, be developed to the most effective extent throughout the New York metropolitan area.

That this development be supported wherever additional facilities are needed for the ambulatory sick in preference to any increase in the number or capacity of out-patient departments devoted to a limited or special field of medicine or surgery, and in preference to independent dispensaries, whether for general medicine or surgery or for any of the specialties. Exception is made in favor

of out-patient services connected with mental and tuberculosis hospitals.

16. That agreements be arrived at by the voluntary hospitals and independent dispensaries on the one hand and the Department of Hospitals of New York City or the competent authority of other local government outside of the city, on the other hand, whereby payment at an established rate will be made by civil government to voluntary institutions for services of acceptable quality rendered in the respective dispensaries to patients eligible for free medical care at public expense. A similar arrangement for payment by the emergency relief bureau to voluntary institutions for the dispensary care of its clients is recommended.

17. That, where they do not exist, standards be agreed upon by institutions engaged in dispensary work, in collaboration with accredited representatives of the appropriate county medical societies, and with public welfare bodies, for determining the eligibility of dispensary patients for free care.

18. That out-patient departments of hospitals and independent dispensaries restrict the admission of patients to a number which can be adequately served.

19. That payment of physicians serving in dispensaries be made by voluntary and municipal institutions when and as financial resources for this purpose are provided.

Ambulance Service

20. That the existing cooperative ambulance system in New York City be encouraged and continued, with such adjustments of district boundaries and numbers of ambulances as experience shows are needed.

21. That immediate steps be taken by cooperative action on the part of public authorities in cities, counties and townships, and by voluntary hospitals and hospital associations in the metropolitan area outside of New York City toward organizing ambulance service on an adequate and efficient basis.

Medical Social Service

22. That measures be taken (1) to hasten the expansion of medical social service so that it will be provided in all the 118 hospitals in New York City which need it; (2) to compare present programs of medical social service with the conceptions of it formulated by the American Association of Medical Social Workers; (3) to establish work unit ratios, which do not now exist, for an essential minimum and desirable optimum amount of medical social service for hospitals of the several types, both general and special.

Employment Conditions of Personnel

23. That all work by nonprofessional personnel in hospitals be paid for in full either by salary, or by salary plus part or full maintenance, at rates corresponding to those paid for similar work in nonphilanthropic establishments in the same community.

That each hospital study its own labor situation and take counsel with other hospitals with a view to making such changes in wages and working conditions as will permit its employees to maintain an acceptable standard of living.

24. That, where not already in effect, the board of trustees of each hospital establish a special committee of the board to take sympathetic and continuous interest in problems relating to employment and welfare of hospital employees.

25. That benefits of the same nature as those specified for similar categories of employees in business and industry under federal and state social security acts be assured for its own employees by action of the board of trustees of each hospital to provide reasonable insurance against the contingencies of illness, old age and death.

Care of the Chronic Sick

26. That the present program of the Department of Hospitals for a center for the medical care of patients with chronic diseases on Welfare Island be endorsed and publicly supported, the first essential for this purpose being a hospital for the chronic sick, affiliated with the medical schools of the city and equipped for medical research.

27. That a modern hospital unit for the care of chronic diseases be provided to replace the antiquated chronic hospital wards at Kings County Hospital, and that consideration be given to the need of chronic hospital service in the boroughs of Bronx and Queens.

28. That for the care of chronic patients a separate children's unit be added to the center for chronic diseases on Welfare Island.

That the present City Home on Welfare Island be replaced by a multiple unit establishment to serve mainly as a custodial division for patients with chronic diseases.

That a system of home medical and nursing care for chronic patients who do not need hospital care be provided under the auspices of the Department of Hospitals as now permitted under the revised City Charter.

That foster home care and visiting housekeeper service be attempted for chronic patients.

That medical social service of a high grade be provided in hospitals for the chronic sick as a means of reducing the amount of institutional care needed by these patients.

29. That the present policy of the City in paying for the care of the chronic sick in voluntary institutions be continued and be so systematized and supervised that such voluntary institutions admit only patients for whose care they are equipped and maintain satisfactory standards.

30. That the efforts of the Department of Hospitals in New York City to maintain standards of equipment and service to chronic invalids in licensed proprietary nursing homes be supported.

Convalescent Care

31. That, with the cooperation of the Department of Hospitals, practical plans for the more effective development of organized convalescent care in this city be made by those concerned.

That the State Department of Social Welfare undertake at an early date the systematic inspection and rating of convalescent homes, similar to the practice in connection with hospitals.

That institutions for convalescent care share in joint financing projects for the support of hospitals.

That, in the area outside of New York City, organized effort be made to provide more adequately for general convalescence, and both in and outside of New York City, for certain race and age categories of patients not now provided for.

Nursing the Sick in Their Homes

32. That the present number of 670 visiting nurses in the New York metropolitan area who give bedside care to the sick in their homes be increased as rapidly as possible until a total of 1,350 such nurses, including supervisors, is reached not later than 1940, and that thereafter at least this ratio of nurses to population be maintained.

33. That regional nursing councils be formed representative of nurses, boards of public health nursing agencies, health officers, public hospital authorities, physicians and interested citizens at large; and that such councils evaluate the community nursing needs before any new services are undertaken.

34. That, except for individuals unable to pay or able to pay only in part, charges for service be based on the actual cost of the nursing visit, and that when patients served in their homes are proper charges upon civil government, the appropriate authorities be requested to pay the cost of the services.

Organized Home Medical Care

35. That medical care of the sick in their homes be included in the general program of the community for organized care of the sick, and be

developed as an extension of hospital and out-patient service.

That home medical care of the sick poor as a tax supported service be developed to the full extent of its usefulness.

36. That such care of the sick in their homes as is directly provided by government agencies be administered by a single government authority in each locality.

That the government agency to be responsible for this service be one which is primarily concerned with the care of the sick; and that in New York City, the Department of Hospitals have this responsibility.

37. That patients be allowed to select the practitioner of their choice under conditions to be determined by the Department of Hospitals.

38. That standards for eligibility of applicants for the free medical service provided by tax funds be determined by public welfare bodies, and that in New York City the Department of Public Welfare have this responsibility.

Control and Coordination of Institutions

39. That jurisdiction now vested in state and local government for the licensing and supervision of hospitals and the like be extended to include all institutions and agencies of a government, voluntary or proprietary character which offer services for the care of the sick, this authority to include specifically institutions serving alcoholic and drug addict patients, and proprietary hospitals which do not accept maternity or child patients or receive public funds, and agencies offering home medical and nursing care; and that appropriations of sufficient amount to permit more frequent and thorough inspection and report upon all institutions subject to official supervision be publicly supported.

40. That the law of the State of New York be strengthened to permit the state department of social welfare to close institutions which have ceased to serve a public purpose.

Maternity Care

41. That in New York City as a whole no additional beds for maternity patients be provided in hospitals now or in the near future.

42. That more effective supervision be maintained by state and local authorities over small voluntary hospitals accepting maternity patients, and over proprietary hospitals offering service to such patients, and that higher standards of professional care be required in both.

43. That both voluntary and municipal hospitals with maternity services extend their prenatal facilities in number and location so that expectant

mothers may have convenient access to these in each borough, preferably on a district or neighborhood basis, determined by cooperative action of these hospitals; and that prenatal services in all instances be administered by the obstetric staff of an institution with a maternity service.

44. That voluntary hospitals be remunerated from municipal funds for all maternity patients eligible for free care, whether admitted as emergencies in labor or as prenatal patients registered with the institution in which they are scheduled to be confined.

Mental Diseases

45. That arrangements be made to develop new psychiatric services in general hospitals and in their out-patient departments to augment those already organized.

46. That the City of New York facilitate the continuance of the Manhattan State Hospital at Ward's Island instead of insisting upon the restoration of the property so occupied to the city.

47. That plans should be made now for the establishment of a number of hospitals with accommodations for 1,500 to 2,000 patients, and that one or more of such new hospitals be designated to serve the special needs of tuberculous patients who also suffer from mental diseases.

48. That there be extension of the service for maladjusted children now established in Bellevue Psychiatric Hospital to other boroughs of the city, when and as psychiatric facilities are developed in other general hospitals, and that existing state hospital facilities be similarly extended.

That state institutional facilities for the feeble-minded be gradually increased until at least 20 per cent of the mentally deficient are provided for.

Tuberculosis

49. That beds for tuberculous patients in special services of general hospitals and in government (state, city or county) institutions exclusively devoted to this disease be increased until there is a ratio of at least 1.5 beds for each annual death from tuberculosis of whatever form or site; that at least 2,500 additional beds for tuberculous patients be provided for the City of New York, of which 1,000 should be in two institutions in Brooklyn and Queens to be built and operated by the Department of Hospitals, and 1,500 in three institutions outside of the City of New York to be built and operated by the state department of health, and to be available exclusively for patients from New York City, the city to reimburse the state on a cost of service for the care of patients in these three institutions.

50. That additional out-patient tuberculosis

services, preferably organically related to general or tuberculosis hospitals, be established under government auspices where needed.

Syphilis and Gonorrhea

51. That an increase in ward beds in voluntary and municipal hospitals for the treatment of syphilis and gonorrhea be arranged for by assignment of beds for this purpose, now used for patients with other diseases, or by adding to the present capacity of municipal hospitals until 1,000 beds for these two diseases are available in New York City at all times; and that comparable provision be made for patients in the remainder of the metropolitan area.

52. That in both voluntary and municipal dispensaries more physicians, nurses and technical assistants be provided, also more dispensary space; and that physicians in all such dispensaries be paid for their services.

53. That antisyphilitic medication for treatment of patients be supplied to private physicians under control by the department of health.

Cancer

54. That the development of cancer institutes and organized cancer clinics in general hospitals be continued and their functioning kept at a high level both of medical personnel and of physical equipment.

That more beds be made available for the treat-

ment of cancer patients in institutions with approved cancer clinics.

55. That further provision be made for institutional care suitable for the cancer patient in the terminal stages of the disease.

Heart Diseases

56. That aside from additional special ward services for cardiac patients which should be encouraged in general hospitals, there be an increase in accommodations for heart patients in homes and hospitals for the chronic sick, and more beds in sanatoriums for acute rheumatic fever patients, and in convalescent homes for cardiac patients.

Dental Care

57. That the general hospitals establish, or where in existence expand the capacity of, dental out-patient services.

58. That at least the children of the kindergarten and primary grades up to and including 4B receive dental prophylactic and educational guidance at public expense when necessary.

Diabetes

59. That every general dispensary provide the properly trained professional staff and the facilities necessary for the competent diagnosis, treatment and follow-up of diabetic patients.

60. That insulin be provided from tax funds for patients who are unable to pay for it.

Medical Opinion on Medical Care

A CONSIDERABLE body of opinion among physicians is in favor of state medicine, in the sense of complete government control over the provision of medical care, it was revealed last month when the report on "American Medicine: Expert Testimony Out of Court" was published by the American Foundation.

This report summarizes opinions regarding the future practice of medicine expressed by 2,100 physicians, most of them men who graduated twenty years or more ago.

The physicians who favor state medicine are divided into two groups. The first group advocates exclusive government control and operation, first, to make medical care available to all; second, because of discouragement with some aspects of present medical practice, and third, because of a desire to obtain economic security for doctors. The second group consists of those who perceive a universal trend toward greater participation by the

government in all essential services. These physicians regard the trend as natural and inevitable.

Views opposing state medicine express fear of political control, and distrust of government inefficiency as well as fear of jeopardizing research and destroying the doctor-patient relationship.

The report also reveals a considerable body of opinion among American medical practitioners in favor of compulsory health insurance as the answer to present problems. On the opposite extreme are those who consider the principle of insurance inapplicable, in any form, to the subject of health.

As to voluntary insurance, the general view is that there can be no reasonable objection to individuals and groups insuring themselves as they see fit.

Suggestions for developments in hospital practice were especially significant. These will be presented in *The MODERN HOSPITAL* next month.



Participants in the healthy baby show.

Birthday Honors

By ETHYL FELT

A PROGRAM to honor the memory of a great woman—Florence Nightingale, the patron saint to whom modern nursing owes its existence, is being prepared by the Mount Sinai Hospital of Philadelphia, for Wednesday, May 12, 1937.

In the morning, at 10:05, a "Tribute to Nurses" will be broadcast over Radio Station KYW, an NBC affiliate. This ten-minute sketch, written by Dr. Maurice M. Malen of Mount Sinai medical staff, stresses the point that "today, nursing attracts the flower of womanhood. Preparation includes a broad basic education. Many training schools require college degrees before admitting students. The training period of three to four years takes place in the hospital. Here the scientific and practical end of nursing is acquired and there is also inculcated a keen appreciation and understanding of the humanities. The art of nursing and the science of nursing are thus welded. Though knowledge is most important, it is never forgotten that the root of all good nursing is the inborn nursing impulse with its eager spirit of service, deep human interest, and warm and spontaneous sympathy.

"Let us remember that wherever the nurse is, she labors to give helpless children, the old, the unhappy, all those who suffer—a chance for health and peace. The surcease of the spirit which surpasses all understanding! Wherever there is a hospital, large or small, wherever in a ward or in a quiet room a nurse fights for the life and well-

being of her patient, there floats the banner of Florence Nightingale."

Another attraction on that day will be the awarding of cups and prizes to the winners in the "Healthy Baby Show." This contest is divided into babies of three classes: six months to one year, one to two years, two to three years. Participants include all Mount Sinai ward babies. Complete physical examinations began in March, and with the aid of the pediatric staff, three winners in each group will be chosen for the grand finals. The awards will be made by a member of the board of trustees.

Later that day, under the direction of the school of nursing, high school students and their counselors from Philadelphia and neighboring towns, will gather for a trip through the hospital. One of the unusual exhibits will be the dietary display, with an explanatory talk by the head dietitian. This will be followed by a musicale and tea. The student nurses will act as hostesses during the entire afternoon.

Arrangements are being made through Mount Sinai Hospital to have a series of "spot" announcements calling attention to National Hospital Day, on all the Philadelphia broadcasting stations on Tuesday, May 11.

As this is the usual custom, Mount Sinai Hospital will keep open house on National Hospital Day for its many friends who wish to visit this modern institution.

Patients First!

By C. W. MUNGER, M.D.

TO SEE a hospital from the inside is to see human life, all its crudeness, all its refinement, all the elements of human reaction and behavior.

The beginnings of life, its artificial lengthening, its termination, are within our ken, and, to a disquieting extent, within our control. Our responsibilities are a constant challenge not only to our ethical attitude toward our work but to our ingenuity in skillfully coordinating the sundry activities which contribute to hospitalization.

The administrator must, of course, be a practical person with ready grasp of the medical and business problems that appear upon the surface—but that is not enough. Our most up-to-date palaces for the sick are, strangely, not enough in themselves to guarantee that the patient is indeed, first. The human elements in patient, in worker and in the public, generally are more nearly the deciding factors in our successes and failures. To an impressive degree, health and even life are at their mercy.

Community understanding is a keystone for the successful hospital. If the patient comes to us suspicious, frightened of hospitals, and with an attitude of "Abandon hope, all who enter these portals," it is very likely the fault of, or a lack of, the public relations program. Hospitals, often wisely, follow the guiding light of the medical profession and I believe our tardiness in publicizing our virtues has been mistakenly borrowed from the code of medical ethics which, to epitomize, says "Do good work but do not talk about it," an admirable code for the individual worker but not wholly applicable to a complicated institution.

Of late, it has been popular to misinterpret certain phases of hospital work, such as maternity care. Without malice, no doubt, and with faint cries, later, of misquotation, Dr. J. B. DeLee, an eminent obstetrician, was widely publicized as having said, essentially, that maternity care was safer in the home than in the hospital! We believe he did not mean it and even doubt if he said anything like it. However, it made the news, and demanded, at once, refutation by hospitals who value public trust and good will. That the challenge seems to have been met is evidenced by

No sinecure for the ill-grounded or unprogressive is the administrator's job

recent nationwide statistics collected by the American Medical Association showing 1936 to have been a banner year for hospital maternity care, both in numbers of infants born and in paucity of complications and maternal deaths.

Hospitals and their work are always good copy. It behooves us to capitalize this fact in an ethical manner, rather than deplore it. Since publicists find us intriguing and interesting, let us by all means see that they understand hospitals and have as ready access to our fine record of accomplishment as to the words of the occasional soapboxer who feels sure he can make headlines by attacking us.

To what extent do we administrators guard the scientific integrity of the hospital's work? Are we functioning merely as institutional martinets, glorified housekeepers, red-ink-abhorring guardians of the balance sheet or prestidigitators in producing calorically adequate diets at lowest possible cost? We need, perhaps, to possess those skills but they are not the means, alone, of fulfillment of our duty to the patient, nor do they guarantee that one's hospital can provide safety to the patient.

The staff, itself, is a topic for the closest administrative concern. A medical degree, we know, is no guarantee of even reasonable medical efficiency. The administrator must be alive to this fact and, through him, his medical and lay boards should learn all known devices for judging competence for hospital practice.

The man selected to head the laboratory and the support he receives from the executive will have vital bearing upon the entire medical work and upon much of the domestic economy of the hospital. An attitude of investigation and research, if genuine, is one of the important safeguards of the medical work. A good laboratory director properly encouraged can bring this about in any medical staff worth having.

The x-ray and other special professional serv-

ices can parallel the laboratory, in bringing fundamental values to the patient. These departments cannot thrive without administrative understanding and help. They are so important that the man or woman who does not appreciate their possibilities and needs, has no place in hospital administration. I, personally, deplore the naïveté of those hospital boards who have thought to cure their depression troubles by drafting the services of persons who know finance but have not the slightest understanding of these scientific values. I predict that, some day, we shall have laws governing the qualifications of those who would practice hospital administration.

Sanitation of the hospital involves broader problems than clean floors and walls and freedom from odors and vermin. These, in fact, are of less importance to the patient's welfare than several less openly evident results of proper administration.

Superdietitians Needed

What about the purity and nutritive value of hospital foods? To what extent is the newer knowledge of nutrition being applied in the hospital? Diet is no longer a mere matter of carbohydrates, proteins, fats and calories. Advances in the science of nutrition within comparatively recent years would, if applied, make possible a sturdier and vastly more effective race. Hospitals should surely lead in applying this knowledge. I expect to see departments of nutrition headed by especially trained physicians or by superdietitians. Only thus can modern scientific advances be fully utilized for sick patients, or, for that matter, for hospital personnel.

Bacteriologic checks on milk supply and even water supply should be made by the hospital itself. They will often bring surprising information to light. To what extent are patients protected from the menace of the diseased employee? Tuberculosis is on its "way out" so we are told, but it is still prevalent among the age groups into which most hospital employees fit, and the threat of the unrecognized tuberculosis carrier is no myth.

Every hospital, for the sake of its patients, of its employees and of its own efficiency, must have an effective employee health service with rigidly required routine physical examinations and medical follow-up.

We are accustomed to read of the relative importance in accident statistics of mishaps that occur in the home. Practically any accident to which a person is liable in the home could presumably happen to him in the hospital, and many more. The fact that avoidable accidents seldom do happen in hospitals is evidence of the extent of our past and present efforts at their prevention.

This vigilance cannot be relaxed—it must, indeed, be extended to encompass the new hazards that arise in connection with new methods and the growing intricacy of the procedures and devices which are being added to our armamentarium against disease and death.

Within my memory, I have never fallen out of bed and I am still disturbed and surprised at the comparative frequency with which this mishap will occur among adult patients unless there are adequate safeguards. Crib-type beds are essential in the care of elderly or restless patients and we should all use more of them.

Explosions of anesthetic gases in operating rooms and similar accidents in connection with oxygen therapy require simple but unrelaxing preventive measures. Wheeled vehicles must be kept in good repair lest they dump out their occupants. Heavy food carts must be kept under control lest they bowl over a hapless employee or even a patient. The spread of communicable disease, which in the home, would be considered an Act-of-God, is less complacently accepted in the hospital. Employee accidents must be prevented for humane reasons as well as to avoid increased compensation rates.

Do you ever follow one patient closely from the time your ambulance calls for him until he is safely back in his home environment? Such a practice would provide illuminating case studies in hospital administration and are advocated. Still better, why not contrive to catch some curable illness and compile the study from your own experiences! We need, definitely, by these or similar means to put ourselves in the psychologic position of the patient we all revere but whose reactions we sometimes so inadequately appreciate.

Approach Must Be Kindly

Reassurance, kindness and personalized care must dominate our patient relationships. Fear is the most potent determinant of the patient's reactions to the hospital. While often skillfully masked, fear and uncertainty of the consequences of illness are nearly always present. Equal or greater skill in human approach is required of the hospital worker who hopes to gain the sick person's trust and confidence. The growing popularity of studies in human psychology by nurses is a portent of better hospital-patient understanding in the future. I, for one, am sympathetic with reasonable efforts in nurse education to produce not only technically trained but really cultured nurses.

While better psychologic approach will mean much, we must also remember to utilize the services of the psychiatrist, freely. The psychiatric methods of former decades are of occasional use in

the general hospital, but much help can be given by modern psychiatrists who understand the bases of human behavior.

The possibilities in the psychiatric approach to hospital employee problems is only beginning to be realized. Psychiatric advice in both patient and employee situations should be sought so frequently and routinely as to dispel the traditional association of the psychiatrist with only the grosser manifestations of mental aberration. If it is required that every student nurse see the psychiatrist during her first week in the school, the thought that such consultations have any connection with insanity ought soon to be forgotten.

While the deeper psychologic processes are less likely to be appreciated, as just outlined, and are

harder to deal with, let us not, in our absorption in them, forget the Golden Rule in our handling of patients and their relatives—their relatives especially. Courtesy, tact and kindness in these relationships are just as important as ever. While we have an addition to our armamentarium when we know, for instance, whether it is better to agree with the statements of the hypochondriac or to gently joke him away from his obsessions, we still need to handle him as a fellow human being, most of whose reactions can be gauged by those of ourselves. If we treat the elderly patient in a manner one would want for one's own mother or maiden aunt, results are apt to be pleasing.¹

¹Read at the meeting of Association of Western Hospitals, Los Angeles, April 14, 1937.

How Would You Rate?

THE following ten questions were the written section of an examination recently conducted by a large city to fill the office of general medical superintendent in its hospital department. Answers were not to be limited to the practices of city hospitals, as the questions referred to hospitals generally.

(1) Describe in detail the method of arriving at hospital per capita per diem cost figures which will permit reasonable comparisons between institutions. (2) Under what circumstances would you employ competitive bidding in the purchasing routine of a 500-bed hospital? (3) Discuss fully the factors which would influence your decisions in arranging for the supply of electric current for a new 500-bed hospital in a large community. (4) Describe fully a plan for the prevention and control of vermin in the various parts of the hospital. (5) Under what conditions are special diets justified in the hospital? Outline plan for the control of these diets from the administrative viewpoint. (6) State the qualifications and describe in detail the duties of the head nurse of a ward. Include a plan for an administrative check up of these duties. (7) Define fully: physical therapy; occupational therapy; radio therapy. Enumerate for each the administrative precautions for safeguarding the patient from injury.

(8) Outline fully the administrative measures to protect an operative patient from errors of any kind which may threaten his life or his comfort from admission to discharge. (9) What are the responsibilities of the visiting staff and the house staff toward the administration, the nursing department, the social service department and

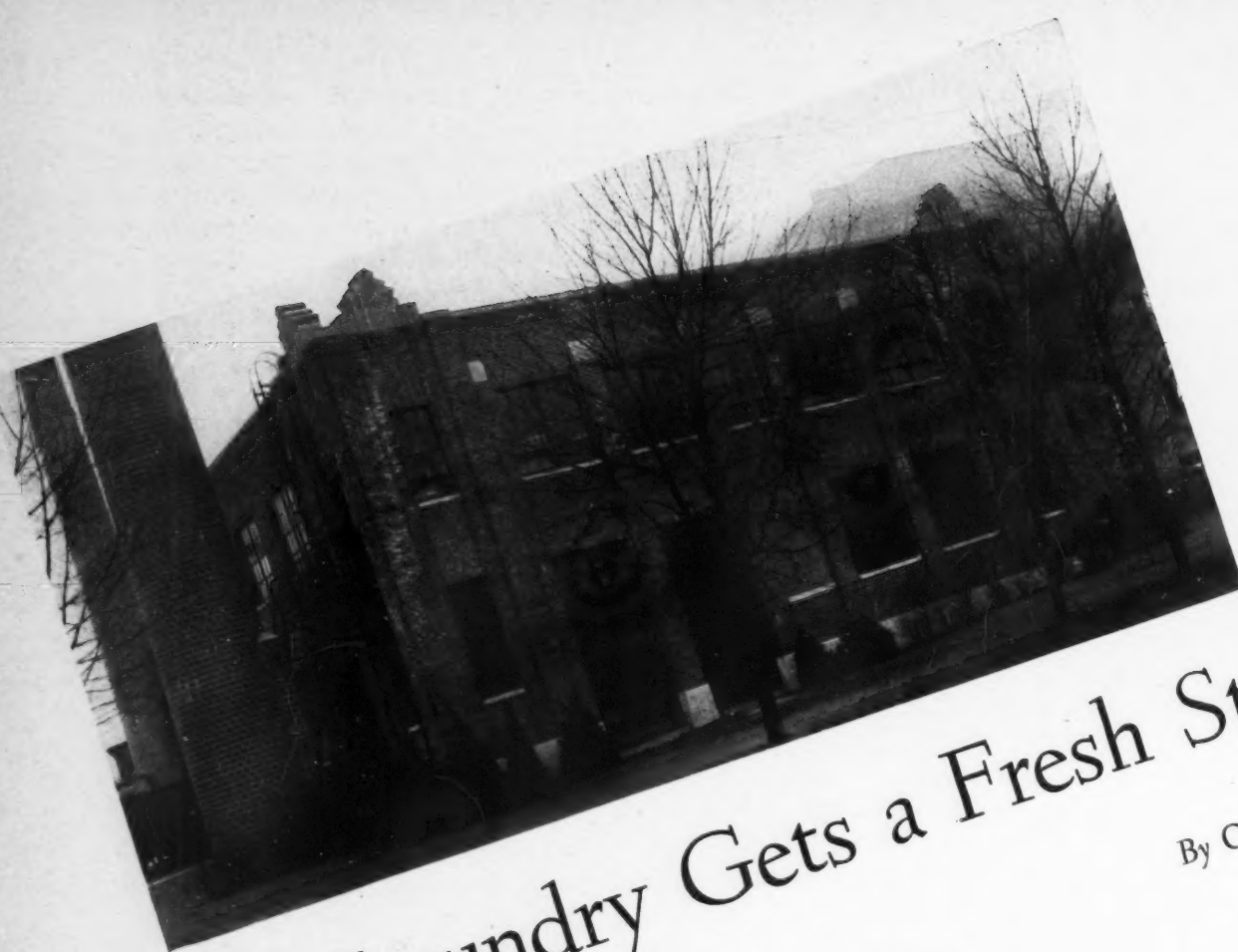
toward each other? (10) Sketch the contents of an ideal annual report to the public on the work of a hospital and describe the various steps involved in collecting and editing.

Applicants for the position of deputy medical superintendent of the same city had to answer, among others, the following questions orally:

Under what circumstances may a subordinate officer appeal to the administration and the governing board of the hospital over the head of his immediate superior? What is the responsibility of the administrator toward a student nurse who is reported to have had a miscarriage in the nurses' home? Name the more common fire hazards in the hospital.

If you were supervising the work of a porter in the open ward during house cleaning hours, what would you look for to test his efficiency? Describe a well conducted fire drill in detail. What is the responsibility of the hospital toward a patient who wishes to leave against the advice of the medical staff? In checking an invoice, before approving it for payment, what would you look for to assure yourself that the bill is in order? Under what circumstances would you approve the reclamation of used gauze in the hospital?

In a 500-bed hospital what would you consider a normal program of administrative rounds for the chief executive? Describe a plan for the control of contraband food in a hospital. Describe an ideal plan of visiting to ward patients for different people, under varying circumstances. How would you deal with an anonymous written complaint? Describe the ideal reception of an applicant in the admitting room.



Laundry Gets a Fresh Start

By O. N. AUER

THE Hubbard Memorial power house and laundry of Monmouth Memorial Hospital, Long Branch, N. J., was erected and equipped with funds bequeathed by John Hubbard of New York City. It was put in operation early in 1936, and the installation of equipment was completed in December, 1936. All laundry for the hospital, which has 207 beds and a nursing school of 100 students, is done here.

The former laundry was housed on the first floor. It had served the purpose since 1910, with occasional changes and additions of equipment which included one 42 by 72-inch monel washer and two 32 by 54-inch brass washers, two standard type 30-inch extractors, a four-roll 100-inch flat work ironer, one pair of tandem presses, three boards and a 42 by 60-inch dry tumbler. The washers, the tumbler and one extractor were driven by belt and pulleys on shafting from one 15-H.P. motor which it was necessary to run if any one of these pieces of equipment was in operation.

The new laundry is on the second floor and

linens are transported to and from the ground level by a large sized automatic dumb-waiter of 550 pounds capacity. The walls and ceiling of the laundry consist of brick and poured concrete. These have been painted white, the concrete floor, battleship gray and the laundry machinery, dark green. A room is provided and equipped with steel clothes' lockers where employees may change their clothes. The accompanying floor plan shows the arrangement of equipment and the line of travel of the material to be laundered.

The new laundry equipment, each piece of which is individually motor driven, was installed at a cost of about \$20,000 and consists of the following major items:

- One 42"x 84" two-compartment monel washer
- One 42"x 72" two-compartment monel washer from old laundry
- One 42"x 36" one-compartment monel washer
- One 48" unloading extractor
- One 30" standard extractor, from old laundry
- One 42"x 90" two-compartment dry tumbler
- One 6-roll 120" flat work ironer with hood
- Two pair tandem presses, one from the old laundry
- Five ironing boards
- One starch cooker
- Steel tables and shelving and steel compartments for personal articles

The three sizes of washers, each provided with



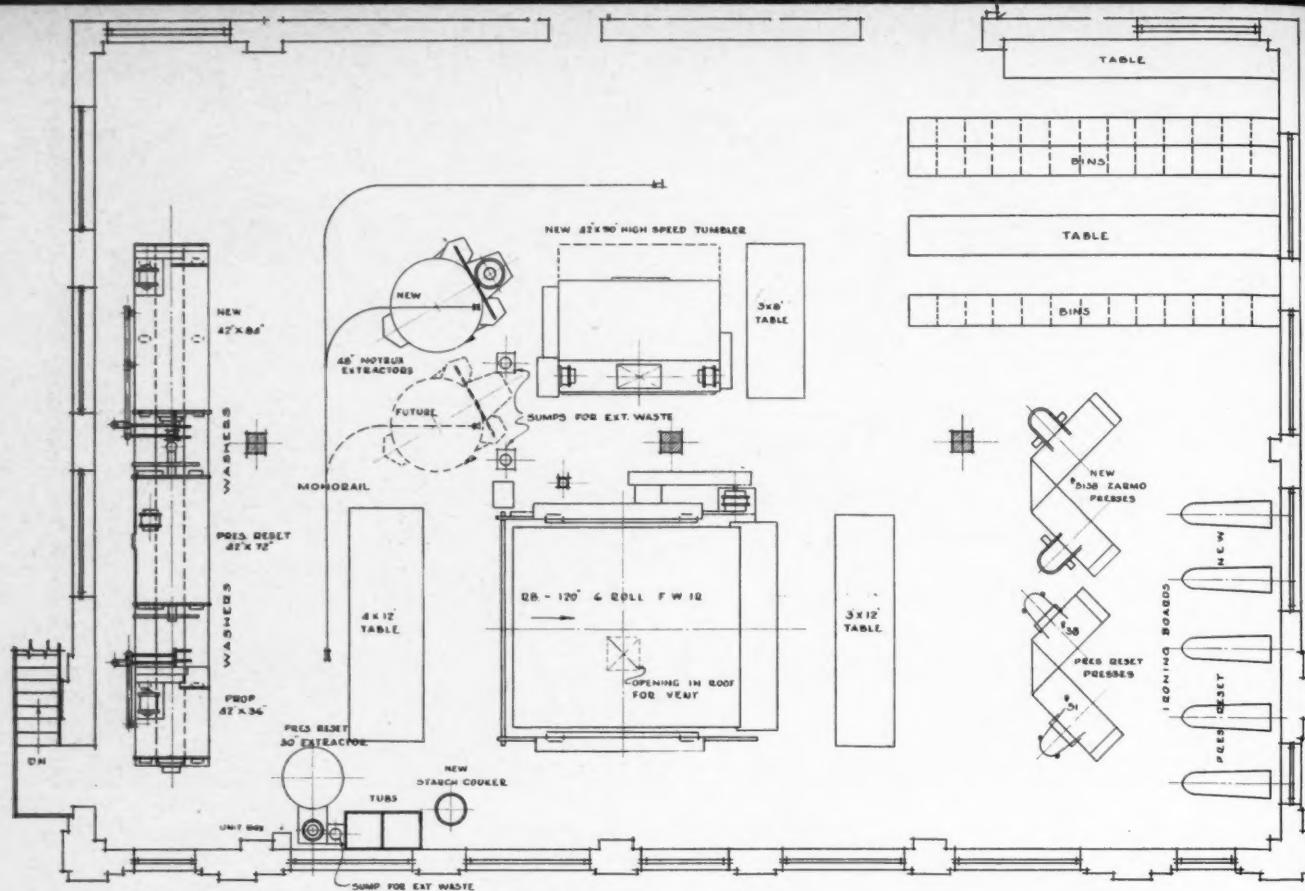
The upper picture shows the monorail for the hoist, with the washers on the right and the extractor on the left. The old laundry equipment appears in the picture on the left; below, the flat work ironer and hand presses.



automatic water level valves and steam inlets for heating water to a higher temperature, make it possible to wash large or small lots. The unloading extractor has a removable cylindrical basket divided vertically into two parts, each of which can be loaded separately. A hoist on a monorail fastened to the ceiling picks it up and one person easily pushes it on this rail over to the extractor where the hoist lowers it into place.

When the extracting is finished, the basket is





Floor plan of the new laundry.

again picked up by the hoist and pushed to a location over the shaking table or over a table in front of the dry tumbler. A latch which holds the bottom of the basket to the sides is released and the contents drop to the table. With this extractor wet linens are transferred by hand only once, while with the standard type extractor, they are handled four times. Wet linens get torn mainly when they are pulled from one container to another, so that damage and mending are reduced to a minimum by the use of the unloading extractor. Its capacity is 425 pounds and it can be handled by one man with ease.

The 30-inch standard extractor is reserved for lots too small to be efficiently handled in the unloading extractor. The dry tumbler has two compartments and is of the once through heated air type, with a lint box and a vent duct to the outside. The old four-roll 100-inch flat work ironer had limited capacity. It was necessary to run sheets the long way and double-thickness articles were only satisfactory if run through twice. With the six-roll 120-inch machine the speed is about 40 feet a minute. Sheets are run the short way and small pieces are run at one end at the same time. It is seldom necessary to run any article twice. A hood was installed with a suction fan in a vent duct leading to the outside. This makes working conditions much better and is well worth the investment, especially in the summer.

The entire personnel consists of nine persons as follows: head laundryman, who also does some

washing; washer man; man to pick up soiled and deliver clean linen, and six women.

The man who handles pick-up and delivery comes in at 6:00 a.m.; the wash man comes at 6:30 a.m. and has washed and extracted several lots which are ready for the others who come at 8:00 a.m. With the new flat work ironer three operators feed and three receive at the same time. Two feed sheets and one, small pieces and these are received by three on the other end of the ironer. The flat work ironer is used for two periods in the day, totaling about four hours. During the remaining hours these women work on the tandem presses and boards and fill requisitions for the hospital divisions. Since only part of the equipment is working at a time, the consumption of steam and electricity is more evenly spread and fewer employees are necessary.

What have we gained beside the satisfaction of having a modern plant to replace an old one? (1) the steam and electric load is smaller although the equipment is larger; (2) one less employee is required than before and an increased load could be handled with the same force; (3) longer life for all linens due to less handling; (4) better work; (5) better working conditions; (6) the new laundry will care for the future as well as the present needs.

With additional workers but no new equipment, with the possible exception of a new extractor, the laundry is capable of handling all laundry for a 350-bed hospital.

Tongue Blades and Administrators

By JOSEPH C. DOANE, M.D.

Is your image reflected here? Are you the "waste basket" type of administrator or perchance the "do it all himself" type? If you are it will show up in your methods of issuing supplies

A REQUISITION is the medium by which the transfer of goods of all types from the general storehouse to the place of their use is initiated.

A requisition may serve as an implement capable of advancing economy and efficiency or it may represent an excuse for carelessness and extravagance. The execution of such request forms requires the expenditure of much time by the sender, by one or more department heads, who visé and approve them, and by the storekeeper, which augments the extravagance of a careless requisition system. If the execution and approval of these forms becomes routinized they depart from the purpose for which they were intended and may do harm rather than further smooth conduct of intramural business.

A study of the methods employed in requesting the issuance of hospital goods at once reveals the type of administration being carried out in any hospital. In a way, it serves to differentiate a good from an inefficient executive. There is a type of superintendent who may be denominated as a "waste basket" executive. His formula seems to consist of discarding the first two requisitions which he receives in order to learn whether a department head is really in earnest or is just indulging in a playful prank. He refuses to act at once and his reason for so doing is a curiosity as to just what will happen when the articles desired are not delivered. If no voice is raised in protest, this type of administrator concludes that he has acted righteously and that the articles requested were not needed.

There is another type of executive who hastily approves and purchases the goods asked. There

is still another who while conversing with an office visitor at the same time signs endless requisitions. This is not an evidence of a highly flexible mind. The requisitions are receiving the benefit of no intellectual effort. Comment on the uselessness of such a practice is superfluous. Nevertheless, it may be said, that it is a pitiful sight to observe a superintendent thus wasting his time. He may just as well not visé any requisitions.

It is believed by many that it is a waste of time for all requisitions to pass over the superintendent's desk. The standardization of department needs having been brought about, the superintendent perhaps might inspect all requisitions at irregular intervals to learn the type of efficiency and economy being practiced. It is folly indeed for the superintendent of a large institution or even for a busy assistant to permit himself, day in and day out, to sign requisitions for cotton, gauze, tongue blades, applicators and other expendables. Perhaps only requisitions for nonexpendable articles such as instruments, rubber goods, cleaning utensils, should come to the immediate attention of a busy executive. If routine inspection of requisitions for both expendables and nonexpendables is to be made it would perhaps be better for an assistant executive or other department head to be assigned this duty. The "do it all himself" administrator can hardly be said to be efficient.

The departmental supervising nurse consumes much time in writing for supplies. It is she who as the administrative officer of a department is requested to secure new apparatus and supplies. If this is not the method employed, the physician may come to the superintendent with his requests. Incidentally, it is incumbent upon the superintendent not to receive such requisitions as emanating from one who is asking for a favor for himself. The one and one hundred different types of articles required, such as tongue depressors, applicators, drugs, soap, milk, crackers, and tea balls represent everyday needs, and requisitions there-

for may easily become just another paper to be signed.

It is felt by some that these supplies should be delivered to a department weekly and hence that there should exist as many sub-storehouses as there are hospital divisions. It is argued that when this is the case transportation, requisitioning and approval time are cut down and efficiency results.

If one's attention is directed to the stock on hand in the average department storeroom he will be likely to find many types of rubber goods, large numbers of tongue depressors, cakes of soap, yards of gauze and rubber tubing, dozens of safety pins and dozens of razor blades. A visit then to the central storeroom or to other department storerooms would be likely to disclose the fact that whereas in one department there is a feast of supplies of various types, in another there exists a real famine.

Practices to Be Discouraged

There seems to be a tendency on the part of graduate supervisors to adopt the methods of an industrious squirrel which stores up against a rainy day. Where a loose system of requisitions is to be found, this sort of wastefulness will surely accompany it. The methods employed in handling institutional gauze serve as a good example of this type of waste. There is a type of institution which may be designated as the "gauze-for-handkerchief" hospital in which nurses, interns and even occasionally chiefs are observed saving on their personal linen by employing surgical gauze as 'kerchiefs. This practice exhibits seasonal epidemic tendencies. This is but a small matter and yet it points towards the absence of an effective requisition system and looseness in handling goods once they have been issued.

In other hospitals one observes at some time during the day a great running hither and yon in search of instruments or materials to perform an emergency dressing. Trips are made to the operating room or other departments, to the accident ward and even to the central storehouse to secure instruments and dressings of minor importance. This type of hospital certainly does not have a central service unit whose business it is to provide at all times sterilized equipment and dressings for the use of hospital physicians. In such a hospital a request for something unusual creates consternation both on the part of the physician and the nursing staff.

There are two methods by which a hospital may be prepared to meet the requisitions of physicians for hurried or even routine dressings or for carrying out on the floors some unusual medical or

surgical procedure. The first concerns itself with providing for every department a complete list of instruments including those necessary for the specialist, and of supplies—gauze, drainage tubes, rubber dam and the myriads of other articles at times required.

An attempt to bring about efficiency by the adoption of this method is bound to lead to extravagance and to an exaggeration of an inefficiency already present. The issuance, for example, of such inexpensive articles as have been mentioned above in their original containers not only brings about an absence of the same type of article in some other department where it is more largely used but also causes increased expense. This system of meeting a hospital need is mentioned only to be condemned.

The second possibility concerns itself with the development of a central service station which has as its purpose a supervised organization of effort so that there will be continually on hand and ready for use sterilized and unsterilized apparatus which may be secured as a result of a telephone call.

To be efficient, such a unit must assume much of the attitude of prepared expectancy possessed by a fire station. The advantages of such a central service division are many. They consist in the main of providing better and more prompt service, of bringing about economy in the use of supplies, of requiring a much smaller initial investment and of bringing about a more refined technique than would be otherwise possible.

Such a service station may be organized in the hospital irrespective of its size with the promise that economy and efficiency will result. It is not my purpose to point to the central sterilizing and tray room as an innovation but to stress the fact that such a division may carry out the sterilization of gauze and its products and also the supervision of other activities usually assigned to individual departments.

Setting Up a Central Service Station

Let us look for a moment at the most suitable site for the central service station and its equipment. In many hospitals the central sterilizing and tray preparation room is adjacent to the operating clinic. It is under the supervision of the clinic supervisor. She often is required to spend time on this work which should be devoted to assisting in the performance of operations. Too frequently insufficient room is allowed the central service station, causing overcrowding of personnel and of table and shelf room. Dependent upon the scope of the duties of such a department will be the square footage of floor space necessary.

The supervision of the splint room, the care of

oxygen tents, Bradford frames, thermostatic bed cradles and all other types of specialty apparatus may well be assigned to the central service station. It is agreed at once that this is not the usual conception of the function of such a department and still if these often expensive articles are centrally stored, fewer will be required than if each department is furnished with a sufficient number to meet emergencies.

The equipment of such a department would, of course, consist of much table space, monel metal covered if possible, and adequate cabinet and bin capacity to care for both sterilized and unsterilized goods, sterilizers, a still, wash sinks, drain boards, flask drying pegs, drum stands and shelves. A separate room for the storage of gauze in bulk, muslin and other similar materials is desirable.

This department should furnish each division of the hospital, as needed, sterile and unsterile treatment trays, sterile dressing trays, intravenous equipment, sterile saline for local, internal and external application, splints and orthopedic equipment, oxygen tents, air mattresses, suction apparatus and special medical and surgical appliances for treatment.

Tray Set-Ups

All trays, both sterile and unsterile, should be issued from the central service station. Such trays may consist of the following: unsterile special mouth trays, enema trays, abdominal packs, wet dressings, flaxseed poultices, mustard paste, douche trays, mortuary packs, Wangenstein drainage, gastric lavage, nasal gavage, gastric analysis, proctoclysis, enteroclysis, cupping and biliary drainage trays. Sterile trays, such as hypodermoclysis, intravenous, lumbar puncture, abdominal paracentesis, chest aspiration, surgical dressing, special irrigations, catheterization, bladder irrigation, eye, ear, nose and throat irrigation, venipuncture, venesection, intravenous pyelography, spinal irrigation and intratracheal application trays.

It is also probable that it may be efficient to expect the central service station to supervise the following trays not originating in the department and usually remaining on each floor: hypodermic, medicine, enema, douche, temperature trays and examining baskets.

Another service which can be expected of this unit is the assumption of responsibility for all ward dressing carts which each morning are delivered from the service station to the floor where needed and each evening returned for servicing. It is unnecessary at this time to list the articles required for each dressing cart, but unless some standardization is brought about in the equipment

and servicing of these carts, delays will result and it will be impossible to routinize and refine the technique of handling clean and infected ward dressings.

Perhaps the most important activity of this station is that which concerns the preparation of hospital solutions. It has been demonstrated that a system founded on the employment of the same flask as a bedside container and as the one in which the solution has been sterilized adds to efficiency and avoids to the greatest degree the danger of contamination by the transference of the solution to a second burette or flask. The use of flasks of this type and in this manner for the administration of solutions intravenously, subcutaneously or rectally is a definite advance in practical bedside technique.

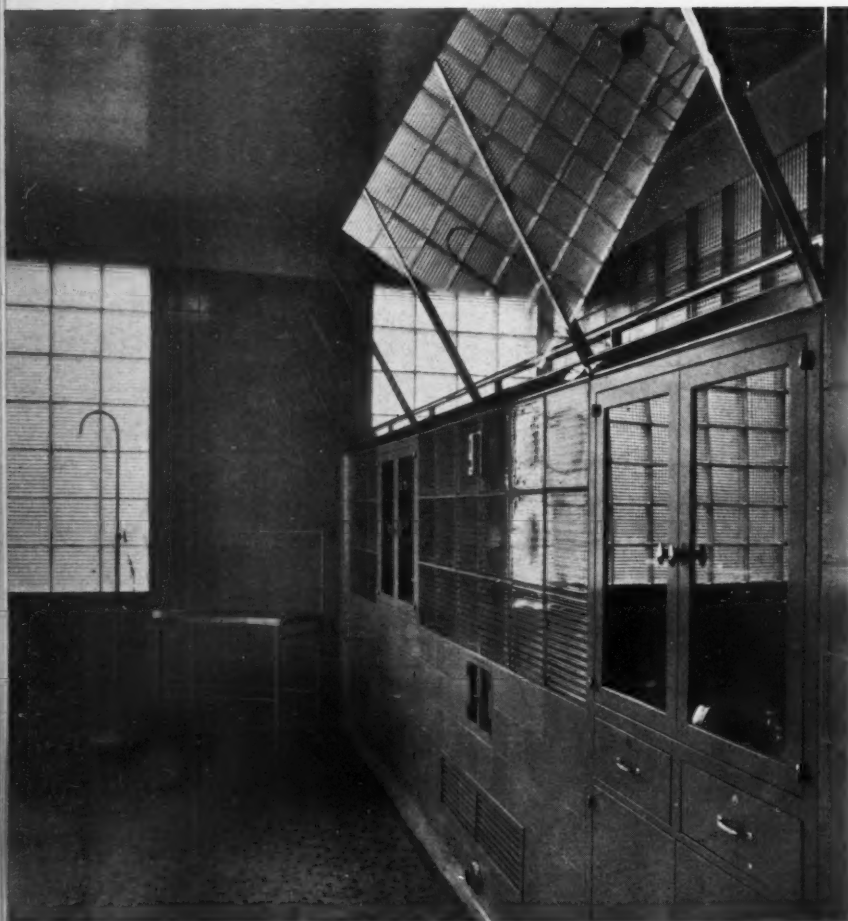
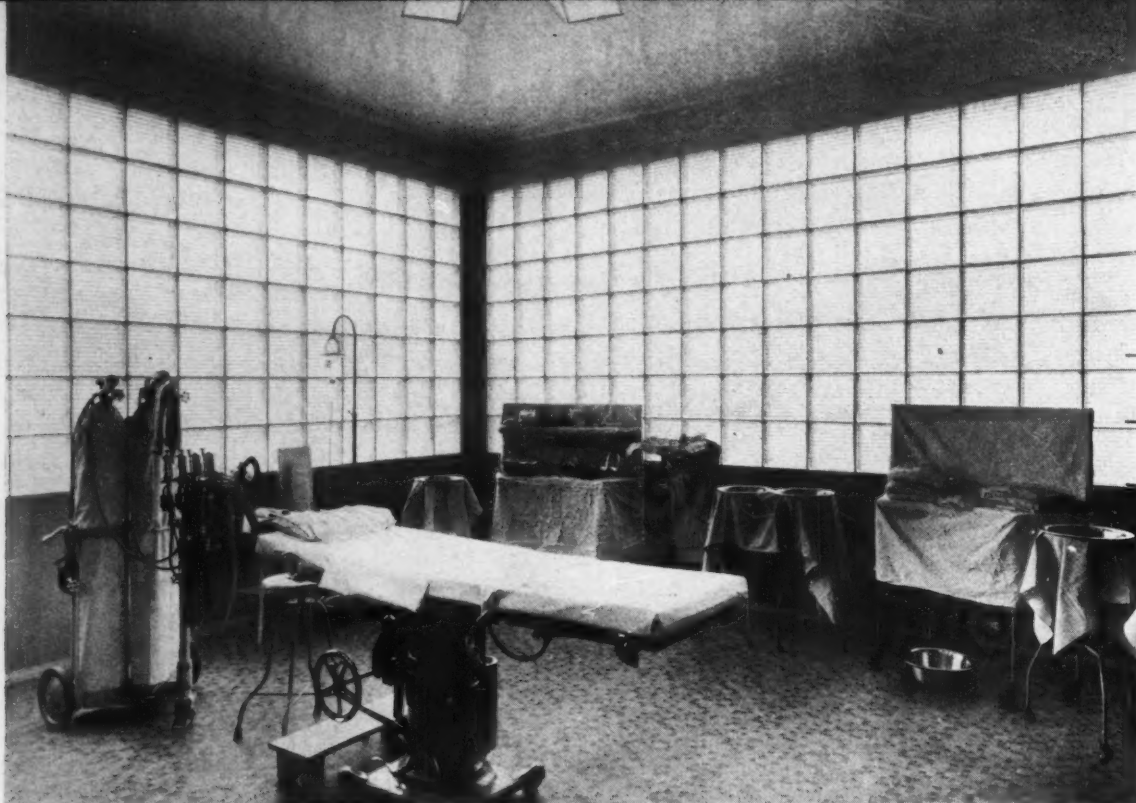
Solutions Needed

These solutions consist of normal saline, distilled water, Ringer's solution, sodium chloride and sodium citrate of various strengths, sodium bicarbonate and glucose of various concentrations. Likewise a central service station may be expected to furnish solutions of various strengths of novocain, cocaine, sodium iodide as well as of mineral oil, glycerin, olive oil and boric acid for external and internal use. When an efficient service station has been organized it is possible to develop a system whereby fresh intravenous and sterile solutions for other uses can be continuously available.

It has been remarked that the splint and orthopedic equipment room might well be under the supervision of the central service station. Such an organization guarantees the proper storage of many types of usual and unusual equipment needed by the orthopedic department and also avoids purchase demands by departments only occasionally employing such equipment.

It may be said by some that the separation of these activities from the attention of supervisors will create unnecessary expense because department nurses previously carried on such work in conjunction with their other daily activities. While it cannot be denied that to conduct a central service station properly requires expert and hence expensive personnel, yet it also can be safely hazarded that the saving in time and materials and the improvement in efficiency will more than justify this outlay.

There must be, of course, a highly trained and carefully selected nurse supervisor at the head of such a department. Her salary will range from \$80 to \$100 a month. An assistant, with but a slightly lower salary, will take her place on occasion since this is a twenty-four-hour activity.



Walls of Glass

AN INTERESTING application of glass brick to modern hospital construction is revealed in the Swedish Hospital, Seattle, Wash. The use of glass in brick form is comparatively recent in this country and marks a trend toward the strictly modern influence.

At the Swedish Hospital it forms the walls of the operating suite of the building, which was designed by Smith, Carrol and Johanson, architects. The view of the operating room shows it as prepared for a major operation. It will be noticed that the room appears practically shadowless and about the only contrast that comes within the range of vision is the relatively low wall brightness as contrasted to the brightness of the construction unit. In other words, while the transmission factor of the glass is extremely high, its brightness is relatively low. From the standpoint of good lighting practice this is said not to be objectionable but rather an aid to eye comfort.

These glass bricks have been hailed by some engineers and architects as offering a more diffused and less glaring light than plate glass.

PLANT OPERATION

Conducted by John R. Mannix and R. C. Buerki, M.D.

Air Conditioning Operating Rooms

By A. J. Hockett, M.D.

A CAREFUL check of temperature records in the South will show air conditioning applicable to more than 180 days during the year.

When air conditioned operating rooms were first under consideration at Touro Infirmary, New Orleans, we felt that it would be wise to inquire about the experience of others. It was rather surprising to find that authoritative opinions based upon actual experience were difficult to obtain. Even the larger hospitals in the deep South have had little experience with air conditioning as applied to operating rooms. Obviously operating room installations represent special problems which cannot be met by ordinary commercial specifications.

A meeting of our anesthetists and surgeons with our consulting engineer to discuss factors primarily of profes-

sional interest was called. This conference brought forth the following suggestions:

1. Humidity control designed to provide relative humidity of 55 degrees was of great importance from the standpoint of the anesthetists in order to control explosion dangers. It was felt that air operated controls would be preferable to electrically operated controls for the same reason.
2. Most surgeons agree that the peritoneum should be opened at a minimum temperature of 80 degrees in order to avoid shock.
3. Air inlets should come from the courtyard rather than directly from the street and all air coming to the operating rooms should be filtered.
4. Noise should be controlled to as large an extent as possible.
5. Drafts should be eliminated both

as a matter of comfort and as a matter of safety to the patient.

6. Air circulation should be independent for each operating room in order to avoid odors or bacteria being carried from one room to another. In order to make the system most effective it was felt that provision should be made for year round air conditioning, especially as regards filtration and humidity control.

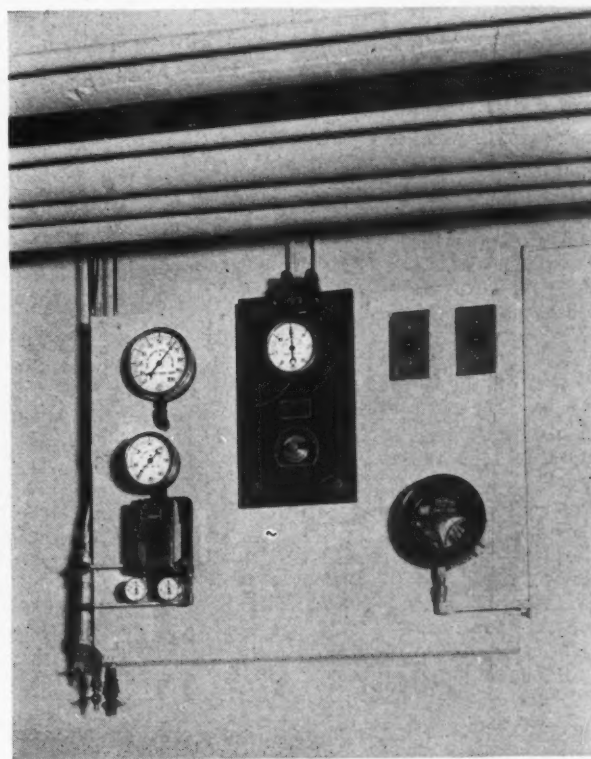
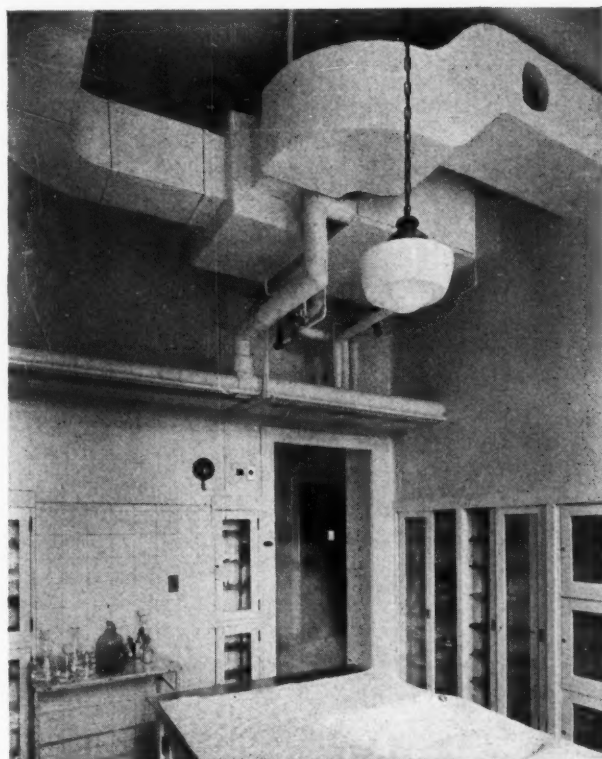
I should like to emphasize the importance of an independent consulting engineer in drawing up specifications for hospital installations. The additional cost will be repaid many times in the satisfaction which accrues from a well planned system. The following specifications were drawn to cover the equipment and installation at Touro Infirmary but could be rather easily adapted to any operating room suite of comparable size.

Details applicable to all types of construction specifications have been omitted for the sake of brevity.

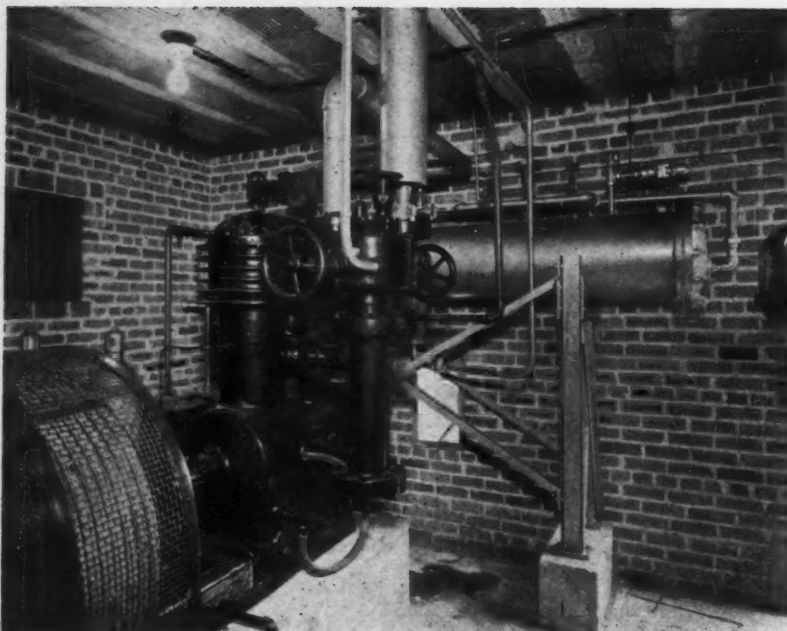
Description of System

The air conditioning system will be designed to maintain the desired year round conditions in the five operating rooms at the Touro Infirmary.

At least 75 per cent outside air will be passed and distributed to the five operating rooms. The individual units will be equipped with cooling coils for cooling and dehumidifying air in summer, and with coils for heating the outside air, and a steam spray for humidifying this air in winter. (The steam spray was substituted for water



Cooling units, of which there are about five in the air conditioning installation, are placed on ceilings of utility rooms. Actual cooling of air takes place within these units. The picture on the right shows the master control panel.



The compressor, on the first floor, compresses the freon in the compressor room. Freon, at about 40°, is then pumped to the conditioning units.

spray because of the difficulty encountered from fans picking up the water spray and depositing moisture in the duct elbows.)

A thermostat and humidistat will be installed to control the desired temperature and humidity of the supply air leaving the units so that proper room conditions may be maintained.

An air operated volume damper will be installed back of each cooling unit which shall control the quantity of air discharged into the rooms thereby maintaining proper summer temperature.

Air operated controls will be installed in order to keep all electrical devices outside of the operating rooms. Owner will supply air at a pressure of 35 pounds.

Refrigerating Equipment

There will be furnished and installed a complete system of refrigerating equipment, which will include compressors, condensers, coolers and control equipment for compressors. Either one or two compressors of equal size may be furnished. If one compressor is furnished, it must be equipped with a two-speed motor and starter. (Note: Single compressor furnished.)

Compressor will be of the vertical, single acting, motor driven type, using freon as a refrigerant. Speed at which compressor is to operate shall be stated in proposal. Suction and discharge gauges are to be furnished and installed.

Motor will be 220 volt, 3 phase, 60 cycle, 40 degrees, of the high torque, low starting current type, and furnished with suitable starter. It will be of ample size to develop specified

tonnage under full load conditions without overloading motor. Motor and motor starting equipment must be of such a type as to limit the starting inrush to that allowed by the New Orleans Public Service, Inc.

Compressor will be complete with control valves, gauges, automatic high and low pressure cutouts and all necessary auxiliaries. It will be piped to direct expansion cooling units and suitable control equipment will be furnished to maintain the desired conditions in the operating rooms.

Complete refrigerant charge will be placed in the system before starting up. At the time of acceptance by engineers, any additional refrigerant necessary to bring the system up to full charge, will be added by contractor.

Condenser will be designed to prevent excessive head pressure on the compressor when the cooling water to the condenser is furnished at a temperature not exceeding 90° F. Water connection to and from condenser will be run by the contractor, who will also furnish automatic water valve and shut-off valve in line. Water line will be brought within 10 feet of condenser by owner. Water pipe will be galvanized steel.

Contractor will run all refrigerant lines between compressor, condenser and coolers. All piping used on refrigerant lines will be copper, made up with sweated joints.

All refrigerant lines will be installed in a workmanlike manner, and will be free from pockets. After the system has been installed, all lines will be properly tested at twice the maximum pressure they must carry and made tight. All cold refrigerant lines will be covered with moulded

cork of standard ice water thickness.

Contractor will install suitable drain connection from condenser, compressor and evaporator pans. These connections will be run to a drain line brought within 10 feet of equipment by owner.

The compressor will have a refrigerating duty of not less than 21.0 tons, when supplied with 2½ G. P. M. per ton of condensing water, with an entering temperature of 90 degrees. It will be on the first floor, and the necessary foundation for supporting the compressor will be installed by contractor. Design of foundations and building supports are to be approved by the engineers.

Isolating cork will be placed between the equipment and the foundations or supports, to prevent the transmission of any vibration to the building.

Conditioning Units

The five conditioning units must be suitable for heating, cooling and maintaining the desired humidity. They are to be designed to pass not less than 900 C. F. M. of air, 75 per cent of which will be fresh air, and to maintain the desired conditions within the operating rooms, under the sensible and latent heat loads specified hereinafter. These units are to have a heating and humidifying capacity sufficient to raise the outside air in winter from 20 degrees to 80 degrees and 55 per cent R. H.

A fresh air supply duct will be connected to each of the five units, the rooms being supplied with 600 C. F. M. each of outside air. These five conditioners will be installed outside the operating rooms and each conditioner will be connected to the room it serves. Each conditioner unit will be designed to operate with a mixture of fresh air and return air, and a return duct from the operating room will be brought back to each unit.

Duct Work

Connection is to be made from the conditioning unit to the air distribution system, using galvanized iron with canvas connectors. All galvanized iron used in the construction of ducts is to be copper bearing metal. All seams to be of type as selected by engineers.

All duct work will be insulated with 2-inch cork board, set in hot asphalt and securely wired. Finished surface of cork board will be covered with mastic and painted aluminum. Any duct work or pipe, subject to sweating, will also be properly insulated.

A galvanized iron duct is to be run from the outside air to the intake of the evaporator. This fresh air duct is to be provided with manually operated damper. The outside end of it is to be covered with 1-inch mesh hard-

ware cloth, and is to be provided with rain hood or louver. The openings in the building walls, for passage of ducts, will be cut and neatly repaired by this contractor.

On the inlet side of the evaporator, contractor will install air filters. Filters are to be of proper size for the total quantity of air entering the evaporator. Type of filter used is to be stated by bidder. Suitable access door is to be provided, so filters can be removed for inspection, cleaning or renewal.

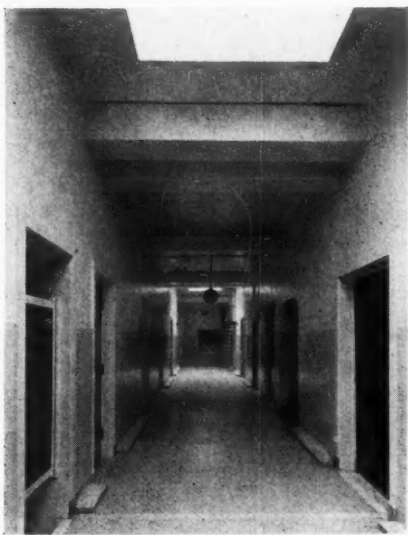
Duct is to be 24-gauge. All sheet metal is to be cross-broken on the four sides. Seams are to be of the drive slip type, neatly made.

Contractor will provide strap hangers, securely riveted to the seams at the side of the duct work and fastened to the ceiling, in order to hold the ducts in place.

All openings through floors and walls for the passage of ducts will be cut by contractor and neatly repaired by him after duct work is in place. Cutting and repairs must be done in such a way as not to weaken the building. There will be provided high velocity supply outlets in the duct work at specified points.

Grilles will be designed so that the air blow will completely cover the area to be cooled. Grilles will be placed on outlet boxes, to give proper plenum effect back of the grille. Each grille is to have a specified discharge capacity and suitable means are to be provided at each outlet box for adjustment to secure the desired capacity. After installation is complete, tests will be made, if required by engineers, to determine the discharge from each grille. Adjustable splitters will be provided where necessary in the duct work.

The duct work will be run in such a manner as to avoid all possible interference with lights and obstructions in the building.



Operating corridor shows false beam treatment of duct work.

Contractor will guarantee that all duct work will be free from pulsation or objectionable noise, that the volume of air, as specified, will be delivered to all points and that the air will be delivered from the grilles, without causing cold spots or objectionable drafts. Contractor will thoroughly inspect the building and plans, and if in his opinion there exist conditions that would limit the guarantee as herein required, then due notice in writing will be given the engineers of such conditions, for which alteration or correction will be made at the time bid is submitted.

Controls

Suitable provision will be made for automatically controlling the temperature and humidity for year round operation. A system of air operated controls is to be furnished and installed by the contractor.

A supply of compressed air at a pressure of 35 pounds will be made available by the Touro Infirmary, who will pipe this air supply to within 10 feet of the location of the conditioning units.

Contractor will install necessary pressure regulating valves and strainers and will pipe from this point to the various thermostats and humidistats required. All air piping will be run with copper tubing and sweat type fittings.

The operation of the two-speed motor driving the compressor will be under the control of a thermostat or of a pressurestat, arranged to cut down refrigerating capacity 50 per cent (or entirely) as the refrigerating load varies.

In addition to the above described control, thermal expansion valves will be furnished for the cooling units and each compressor will be equipped with a high and low pressure cutout.

Steam for heating coils will be available at a pressure of 10-50 pounds and will be piped to within 10 feet of the central conditioning unit.

The heating coils, located in the units for each room, will have sufficient capacity to raise the temperature of the supply air from 60 degrees to the temperature necessary to care for the heating load in each room.

As shown in the photograph, the false beam treatment of duct work has given us a satisfactory result as far as appearance is concerned. All conditioning units are placed in the utility and dressing rooms to the left and are separated from the operating rooms by a distance of about sixteen feet.

The cooling units which number about five in the air conditioning installation were placed on the ceiling of the utility rooms. They are connected with the compressor which is on the first floor and which compresses the freon in the compressor room. Freon is then pumped to these

conditioning units at a temperature of about 40 degrees. The actual cooling of the air takes place within these cooling units which are typical of many central plant installations. There is only a small amount of duct work shown in the picture but the cooling units are completely closed, in order to protect them from dirt and give them a better cosmetic effect. The compressor has been placed on the ground floor and the system may be truly termed a noiseless one. The total cost of this installation amounted to \$8,500.

Two other minor details should be mentioned. Unless the insulating material used in the duct work is carried between the walls, sweating will occur at this point and the wall will deteriorate rapidly. We found also that, due to the low speed fans used for this installation, not enough air movement is produced to activate the controls used. It was therefore necessary to place louvers near the controls to obtain increased airflow at this point.

We have found the members of the staff pleased with the results obtained by this installation and believe it at least approaches the ideal equipment for air conditioning of more than a single operating room. Experience has shown a five-degree temperature differential to be adequate for comfort during even the warmest season. The average summer temperature in New Orleans for a period of about six months would probably be around 92 degrees. We have no temperatures over 100 and seldom under 85 degrees in the summer. The humidity, however, runs high, averaging about 83 per cent.

Walls Put on a Stone Face

When is stone not stone at all? The answer is revealing. When it takes the form of a multisided plastic texture material ready mixed for application with a brush or trowel to any wall surface. This product, to be more exact, has a base of cement and oil. One application and the wall takes on the form of stone finished coarsely or with a surface as smooth as highly polished marble.

Ceilings, too, respond successfully to such treatment, particularly when an old English effect is desired. It is also surprising what miracles it can perform in simulating a stone fireplace either for the nurses' library or executive offices. For such purposes, it comes prefabricated in large sheets which cut and fit like lumber — ideal for false linings and hearths.

Plain colors in oil can be added to provide greater warmth and variety in effect. Maintenance is simple. The finished surface is fire resistant, is not affected by heat, cold or moisture and can be kept clean and sanitary merely by washing with soap and water.

Lessening Anesthesia Hazards

By John H. Hayes

Hospitals should bring this article to the attention of all who handle compressed gases

THE widespread use of gases in hospitals by persons with little knowledge of hazardous possibilities has resulted in some accidents, both in hospitals and in gas plants—few, it is true, but the dangers are great. Inasmuch as I have spent fifteen years in the compressed gas business, and in addition have managed a large hospital for the past eleven years. I believe I can write helpfully on this subject.

It is natural that oxygen and anesthetic gases should cost less when sold in large cylinders. Hospitals have been hard pressed during these recent years and some have economized by the purchase of gases in large cylinders, transferring gas from them to the smaller cylinders used on the anesthesia machines. Some use the gases directly from the large cylinders. Practically all now use oxygen in pneumonia treatments from the large cylinders. Enough cannot be said against the practice of refilling small cylinders in a hospital. Such small cylinders are not inspected, cleaned or tested and certainly must gather in them dangerous gases or substances, as will be shown later.

This, then is a false economy and a distinctly dangerous proceeding. First, these small cylinders are probably only loaned to the hospital even though a deposit has been paid. This is a misuse of property. Second, hospital employees have been known to fill small nitrous oxide or carbon dioxide cylinders with oxygen from large tanks, not realizing that these gases might have been compressed with oil, which if present with oxygen has dire possibilities.

It Is Resolved That—

The executive committee of the Compressed Gas Manufacturers' Association, on April 16, 1936, passed the following resolution:

"RESOLVED, That in the interest of safety, the Compressed Gas Manufacturers' Association recommends that the practice of transferring gases in hospitals be discontinued and that medicinal gases be used in the cylinders

as supplied by the compressed gas manufacturer."

Some hospitals use large cylinders directly connected to the anesthesia machines or piped to the operating rooms from a central battery of cylinders. This practice does not involve any unusual dangers, but in the event valves are left open, as they often are, the attendant loss is much greater.

Gas anesthesia involves the use of oxygen and nitrous oxide (both supporters of combustion), and ethylene, cyclopropane and ether, all inflammable gases or vapor. In addition, mixtures of oxygen and carbon dioxide are usually available for resuscitation purposes. Here we have an explosive mixture, not mixed at the point of combustion, as in welding torches, but in bags, tubes and glass bottles from which it is fed to the patient in varying percentages and doses. Within the same room live cauteries are used, and often immediately adjoining there may be a sterilizing room with a large gas flame going. It is surprising that accidents do not happen oftener. I do not wish to cause alarm, as accidents are rare, but it is my desire to make such accidents impossible by calling attention to what may happen if proper precautions are not taken.

Anesthesia Machines

Anesthesia machines are delicate instruments. They are made for fine adjustment, and the many improvements in their manufacture have made possible the ideal anesthetics given today in which there is no discomfort in induction and rarely any in the after effects. Compare this with former days when taking any anesthetic was equivalent to choking, and the after effects were sometimes worse than the ailment to be cured.

Anesthesia machines are expensive. Hospitals in general own various kinds and vintages of such apparatus and doctors and anesthetists have preferences determined by types of operations or personal prejudices. This means that these machines are moved from one operating room to another. In addition, in most modern hospitals, anesthesia rooms are provided on the operating floors, removed from the operating rooms, in order that anesthesia may be induced therein and the patient prevented from seeing the operating room.

This means movement of the anesthesia apparatus, which follows the patient on the stretcher. The result is

bumping the machine either into walls or over door sills, often affecting the smooth operation of the apparatus.

Let me here mention briefly the types of accidents that have occurred in hospitals and gas plants in some instances on only one occasion and in others oftener.

Breathing bags attached to gas machines have burst or exploded while in use. Cylinders have burst in operating rooms due to propagation of flame from the anesthesia machine to an explosive mixture in the cylinder. A cylinder exploded in a gas plant and another in a freight station merely on being handled. Oxygen tents and rooms have burst into flames. Fires and explosives have occurred in operating rooms without originating in machines or cylinders, but due to dangerous mixtures in the atmosphere and accompanying spark or flame.

Avoiding Sparks

Much has been written regarding the avoidance of sparks or flame in operating rooms.¹ Careful management provides for sparkproof switches, vaporproof globes over all lights, and in other ways attempts to prevent accidents due to sparks, all of which somehow seems foolish when we see in the same room white hot cauteries and electrically operated suction apparatus and other equipment which might easily cause accidents.

Static sparks are a continual source of danger in dry atmosphere, and some hospitals have humidifying apparatus operating on a humidistat to prevent them. Others have air conditioning apparatus which increases and controls humidity. It is highly desirable to provide proper ventilation so controlled and directed as to remove and dilute accumulations of explosive mixtures. The exposed patient and well covered perspiring workers must also be considered and drafts should be avoided.

Ether has been the cause of many accidents, either through explosive mixtures in the operating room or because of being drawn back into empty cylinders. Operators of anesthesia machines are generally careless in turning off the cylinder valves. They turn off the valves on the machines and think that is enough. Invariably they do not bother with the valves of empty cylinders and often when a cylinder is exhausted they do not even trouble to turn off the machine valve in their anxiety to release more gas or oxygen promptly. When anesthesia machines are equipped with check valves this practice is not so dangerous, but even these valves can get out

¹ Phillips, V. B., *Safeguarding the Operating Room Against Explosions*, Mod. Hosp., 46:81 (April) 1936; and Phillips, V. B., *A Proposed Code of Safeguards Against the Anesthesia Explosion Hazard*, Mod. Hosp., 46:81 (May) 1936.

of order, due to their light manufacture or to mishandling.

What happens then is that gas passes from one cylinder to another; sometimes oxygen passes to an empty ethylene or cyclopropane cylinder or vice versa, and forms an explosive mixture. Another cause of explosion is that operating rooms are usually very warm. Anesthesia machines are removed from such warm rooms to cooler corridors or storerooms, causing empty cylinders to cool with a resultant contraction of remaining gas which then creates suction on the line and ether is drawn from the ether container back into the cylinder.

Many gas cylinders have been returned with ether in them. When such cylinders are oxygen cylinders or perhaps nitrous oxide cylinders, ether-peroxide is formed, a chemical formation which is, perhaps, as explosive as T.N.T. This mixture is without doubt the cause of two recent explosions of oxygen cylinders, one in a gas plant and another in a freight station, either one of which might have occurred in a hospital. In each case the cylinder exploded promptly when being handled.

Many reasons have been suggested which might have caused the explosion at that instant, such as disturbance of the chemical compound itself or movement of dust or iron particles in the cylinder. Another authority states that the catalytic or pyrophoric action of finely divided iron within a cylinder is a possible source of ignition.

Position of Cylinders

One authority states that cylinders with explosive mixtures in them are safest in an upright position, with the dust particles undisturbed. This practice is usually followed in operating room areas unless racks are used for cylinders, but not in storerooms where such cylinders are exchanged with the manufacturer. It also would not protect the manufacturer, as has been shown in one instance when an employee was killed while removing an empty cylinder from a horizontal position to the upright position for filling.

Therefore, manufacturers of anesthesia apparatus would do well to look into the construction of their machines. Those who do not provide check valves should do so and all should see that such check valves are sturdy, fool-proof, and certainly proof against the passing of gas or ether. Due to the power of ether as a solvent, the material used in valve seats is important in this connection.

I believe that every anesthesia machine should have on it a permanent and prominent sign reading: "Every cylinder valve must be promptly turned off when finished, whether the cylinder be full or empty." Manufacturers of gases are willing to supply

sufficient hand wheels to keep one on each cylinder while on the machine, ready to be operated in opening or closing each cylinder. Hospitals should require their use.

I believe manufacturers should provide a safety nut on large cylinders of inflammable gases to safeguard them further against leaks in transit or storage.

Whether hospitals know it or not, many of them are sending back to the manufacturers' plants full and partly full cylinders, because of careless operating room management. This can be prevented by better storeroom and operating floor management or by means of seals or other methods of identification provided by gas manufacturers.

The Intern's Part

Hospitals could well afford to give all interns more instruction in the working of anesthesia machines. Many hospitals employ only nurse anesthetists or doctors who specialize in anesthesia, but it is conceded among medical men that all interns should be instructed in this specialty which is such an important branch of medicine.

As oxygen is used in homes, every student nurse should be taught oxygen administration.

Many hospitals now use rebreathing apparatus on some or on all of their machines. This is done as an economy measure, but it also has the advantage of practically preventing the escape of explosive mixtures into the operating room atmosphere. Some anesthetists believe they have better control with it. Gas manufacturers may feel that it decreases their sales. Perhaps the greatest incentive to the use of rebreathers is the growing use of cyclopropane, a very expensive gas if used without rebreathing.

Another precaution in the use of anesthetic gases is in the "cracking" of the cylinder valve before it is placed on the machine or machine connection. This saves the shock of sudden high pressure on the machine and provides smoother operation.

Gas cylinders should not be stored on the operating floor, except enough for the day's supply. This also promotes better cylinder turnover, as the storeroom keeper is not as likely to overorder or underorder as is an operating room supervisor.

Hospital employees in general do not fully appreciate the hazards in handling gas cylinders. With a tremendous increase in the use of gases, particularly oxygen, larger stocks are carried and almost any available space is used for storage. I have seen as many as fifty large sized oxygen cylinders in a basement storeroom in a hospital, with an overhead electric light hanging by a loose cord, frayed and worn, with no ventilation except

the keyhole in a wood door. Ethylene is often stored with the oxygen and nitrous oxide. Ether is generally kept in the drug department, where it should have all the precautions which should be taken with gases. Hospitals unable to provide cool ventilated spaces for gas cylinders should keep them out-of-doors protected from the weather.

Although I have no figures to offer, I am certain that the use of oxygen in the treatment of respiratory and cardiac diseases has increased at least tenfold over the past few years. I am sure that some large hospitals now use more commercial oxygen than did some of the large welding shops in their busy days. I fear that in many hospitals it is used with as little fear of danger as is Epsom salt.

Oxygen is used with nasal catheters, masks, tents (either with or without motors) and, in a few instances, in oxygen rooms or chambers. There is not much danger connected with its use by catheter, except in a small room with a leaking cylinder in reserve. Hospitals should provide large signs reading: "No smoking, lights or flame in this area," to be posted promptly when oxygen is given. Tent manufacturers might print this on three sides of each tent. Visitors to private patients unknowingly enter rooms where tents are in use, smoking, or they light cigarettes in such rooms if they are not warned. It has happened that a patient lit a cigarette smuggled to him by visitors while in an oxygen tent. Naturally, he was frightfully burned.

Altogether too many people handle these oxygen cylinders. Reducing valves and gauges are constantly broken through misuse and varying percentages of oxygen are fed to patients, whereas accurate doses could more readily bring about the desired results. Testing of oxygen content is often done by inexperienced persons. Tents leak or are not properly adjusted to the bed clothing. All these things, aside from dangers involved, reduce the therapeutic value of the oxygen given and are often wasteful as well.

One Man's Job

Every large hospital, at least, could well afford to employ one technician whose sole duty would be to watch the administration of oxygen, inspect the anesthesia apparatus and resuscitators, and perhaps also keep in condition the electrocardiograph and basal metabolism apparatus, and even do minor repairs on x-ray equipment. A good mechanic, preferably an electrician, would not prove an expense in the end. It would be necessary for such an employee to live in the hospital and be available for night calls and inspections of oxygen administration and analysis.

Gas manufacturers should instruct their plant men to be continually on the lookout for evidences of misuse of cylinders and valves, strange odors in cylinders returned and other indications of improper use of cylinders, and hospitals should be promptly informed of such facts so that they may avoid serious accidents.

Many hospitals publish for their interns and nurses various rules and regulations, which such workers are asked to study and obey. These might well include a brief set of rules concerning the use of gases, such as the following:

Do not store gas cylinders in operating rooms.

"Crack" cylinder valve, by opening it slightly and then closing it, before placing on machine. When ready for use open the valve slowly and completely. Avoid undue force.

Turn off gas cylinder valves immediately when finished, whether cylinder be empty or full.

Do not store gas cylinders in non-ventilated spaces.

Report all sparking motors or

switches instantly to the proper person.

Do not fill small cylinders from large ones or transfer any gas from one cylinder to another.

Make certain that the cylinder you intend to use contains the gas you want. Remove wrapping paper and examine label.

Worn regulator connections should be promptly replaced.

When ethylene or cyclopropane is preceded by nitrous oxide induction, turn off nitrous oxide valve before opening ethylene or cyclopropane valve, or vice versa. Do not attach ethylene or cyclopropane cylinders and nitrous oxide cylinders to the same gas machine at the same time unless the machine has been designed for use with both gases.

Do not try to force connections to cylinders or apparatus.

Report promptly all equipment not in proper working order. Do not attempt to repair it yourself.

When gas or ether is used see that room is properly ventilated. If possible, see that humidity is at least 55 per cent.

The walls in the different rooms are painted in a dull, flat paint; here also are used standard colors, dark eggshell or ivory walls in rooms with maple furniture, soft blue, green or a very light salmon pink in rooms with painted furniture. Wood trims in the rooms are a shade darker than the walls, except the doors. These are stained oak. All colors are in subdued, mellowed tones, so that wall and furniture make a pleasant and quiet background for draperies, chair covers, screen curtains and bedspreads which are colorful.

Cleaning of furniture and walls is no difficult job. Washing with a pure neutral soap, followed with a thorough rinsing of clear water, will do the work.

Choosing Fabrics

We use cretonne-linen-percale and Indian head as material for our chair covers and draperies in our patients' rooms and sun parlors, and as bedspreads in our guest suite. Attractive effects are obtained by utilizing a fabric that lends itself equally well to draperies, chair covers, and spreads. In each case the fabrics are guaranteed sunfast and tubfast. Color and design can be gay and informal, but at the same time it is wise to play safe, that is, to be sure that the design is merely gay and not gaudy.

All draperies, curtains, chair covers are made in our own well equipped sewing room and one woman is occupied most of the time exclusively with this kind of work. The draperies are plainly tailored as are the window curtains, avoiding material that will easily stretch or pull out of shape. Material 36 inches in width should be used for each drapery or curtain on a 42-inch wide window, as anything narrower makes a skimpy appearance and lacks charm.

The draperies and curtains have a heading of one inch, a two-inch hem at the bottom and a one-inch hem on each side, so that they can be hung on either side. The draperies go about six or eight inches below the window sill. A tie-back is provided for each drapery to keep it in place and from blowing against the window screen. The glass curtains are made the full length of the window but stop at the window sill. We use a plain scrim in ivory color.

In mounting the curtains and draperies it is wise to set the rods well back toward the edge of the window frame, as in this way one gains the appearance of a larger window. There are many different types of curtain rods. In fact, there is a special rod for every kind of curtain and drapery. Rods that are covered by draperies can be extremely simple. The mountings we use for our draperies are 12-inch brass swinging rods with a round brass knob on the end.

Pleasant Rooms for the Patient

By Martha Blanck

TODAY more than ever before careful consideration should be given to the environmental needs and comfort of the patient. Give him a pleasant room, walls painted in soft tones as a suitable background against which furniture and decorations will appear to advantage.

Modern furniture with simple lines, and bright, cheerful draperies, will give the room personality. A reading lamp may be placed at the head of the bed, a mirror, a dresser and a comfortable armchair. Nothing confusing should be visible, nothing to suggest that this room is anything but a tastefully furnished guest room. If the patient can be made to feel more like a guest of the institution it will tend to hasten his recovery.

The solariums should have the appearance of sun porches in a private home rather than in an institution. Comfortable wicker or maple furniture should be covered with colorful, heavy, glazed chintz. There is a heavy quality of chintz on the market that can be cleaned very easily with a damp cloth and that wears splendidly; also Basque plaids, checks and stripes, monk's cloth, and novelty weaves may be successfully used.

Foliage plants and flowers on win-

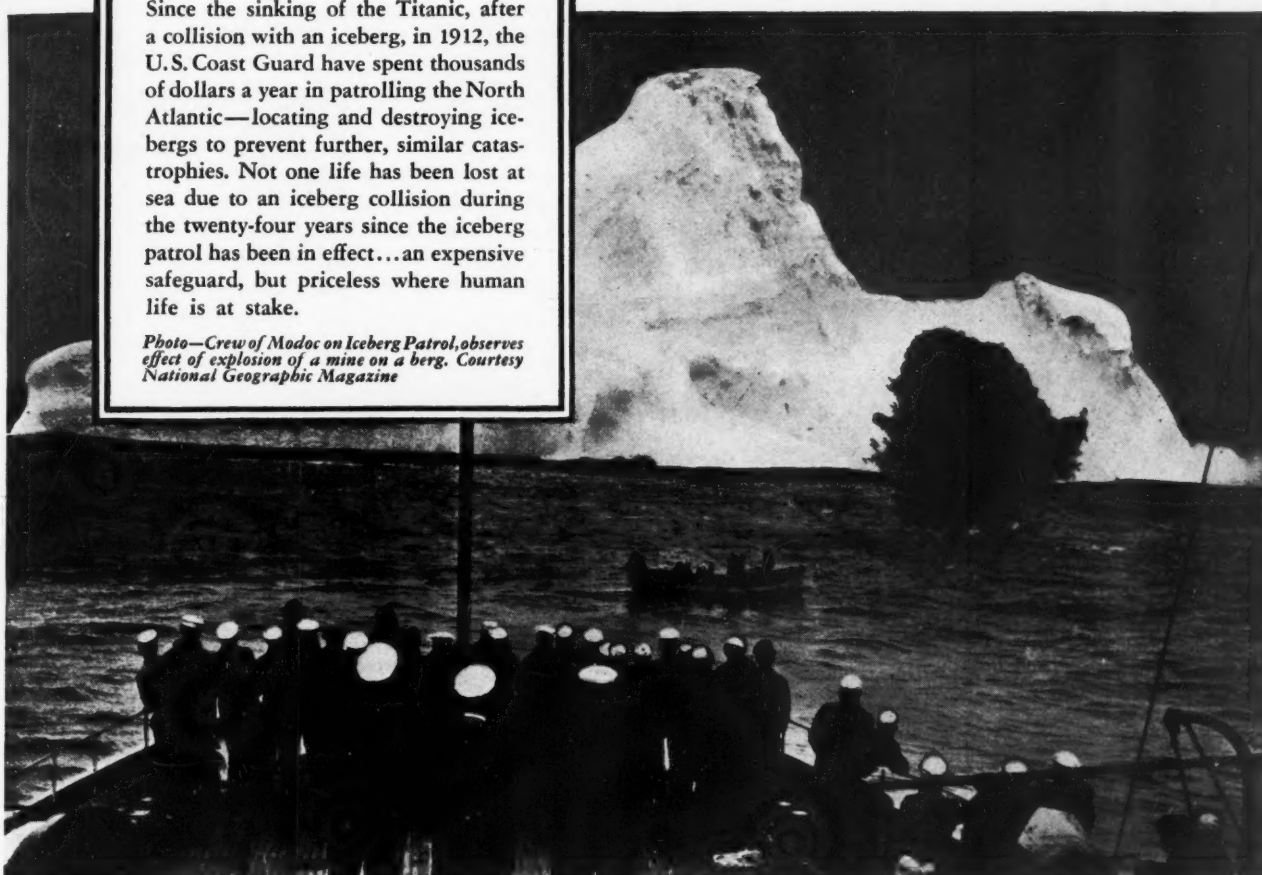
dow sills or in well designed stands will add to the beauty and atmosphere of the room. But remember to select plants that will tolerate the hot and often dry air of our modern buildings. Provide shallow, galvanized iron trays, made watertight and filled with sand or pebbles. These will collect and hold the water which goes through the pots and so supply a little moisture to the air in the room.

All private and semiprivate rooms at Orange Memorial Hospital, Orange, N. J., are equipped with modern furniture. Some are maple in a warm, honey-colored tone, in a stain with waterproof and acidproof finish. We use soft, delightful tones of blue, green, ivory and purple on our painted furniture. The work is done in our own paint shop. Standard colors are maintained so that in repainting a single piece of furniture or a whole suite, no experimenting or guesswork in matching colors is necessary, thus saving time and work. The painted furniture has thin decorative lines in a darker color around dresser drawers and knobs, also following the simple lines of beds, tables and chairs. The lines are applied with a striper, a small tool easy to handle. A painter with little experience can do the job.

TO SAFEGUARD LIVES AT SEA

Since the sinking of the Titanic, after a collision with an iceberg, in 1912, the U.S. Coast Guard have spent thousands of dollars a year in patrolling the North Atlantic—locating and destroying icebergs to prevent further, similar catastrophes. Not one life has been lost at sea due to an iceberg collision during the twenty-four years since the iceberg patrol has been in effect...an expensive safeguard, but priceless where human life is at stake.

Photo—Crew of Modoc on Iceberg Patrol, observes effect of explosion of a mine on a berg. Courtesy National Geographic Magazine



So, too, are Saftiflasks Safeguarded!

40 years of experience in the production of products for intravenous injection, have taught Cutter technicians that no solution for intravenous injection is safe until *proven safe* by meticulous bacteriological and physiological tests.

To be sure, skilled hands, masters of intricate equipment and apparatus, guided by minds trained for years in their own particular branch of science, are responsible for each exacting step in the preparation of dextrose and other solutions in Saftiflasks.

But, *despite* exacting care in production—no Saftiflask can reach your hands until the lot of which it is a part has been *proven safe* by rigid chemical, bacteriological and physiological tests put on by testing experts entirely divorced from the production group.

Then, as a final precaution—to give you

visible assurance that the solution has not been accidentally exposed to contamination—every Saftiflask is doubly safety-sealed; by vacuum, and by an easily removed viscous seal.

And what do you pay for this assurance that every possible care has been taken to make your dextrose solutions safe? Actually, on the basis of direct costs alone, these ready-to-use solutions in Saftiflasks are less costly than those prepared from concentrated ampules. And, when all of the indirect costs are carefully evaluated, they will be found to be no more costly than those prepared from raw chemicals.

Saftiflasks are manufactured by The Cutter Laboratories (U. S. Gov't. License No. 8) of Berkeley, California and 111 No. Canal Street, Chicago. They are available from strategically located distributors throughout the country.



Saftiflasks



Members of Hospital Exhibitors Association

Screen curtains are made from the same material as the draperies in each room, with a 1-inch heading on top and bottom.

The upholstered armchairs in our patients' rooms have slip covers, some of the same material as the draperies and screen curtains, and others in a plain fabric, but always they are harmonious in texture and color. Slip covers vary in the way they are made. Some are tight covers that fit over chairs. Others are slips, with an extra cover for the loose cushion. Covers either snap on to the furniture or have the new mechanical construction, called the "zipper," to close the opening. We use mostly the "snap-on-to" method.

Slip covers are either tailored or have flounces which may be box pleated, side pleated or full. The seams are flat or bound with the self material or with a contrasting material or color. The flounce is trimmed in a binding or facing of the same fabric as that used at the seams of the cover. A bias binding, bought ready-made, in a plain color on printed as well as on plain fabrics always makes a good effect. It is not expensive and washes well. A slip cover must be made loose to allow for shrinkage.

The seats of wicker furniture in the sun porches also have covers which can be replaced easily, with drawstrings at the bottom. As for durability, no material will last forever, but

with a sturdy background, that is, good sunfast and tubfast material and good workmanship, slip covers stand years of wear.

Each room gets two sets of draperies, curtains, screen curtains and chair covers to provide replacement for laundering. This is economical and permits each room to be put in order for new occupancy at a moment's notice. To make our rooms in the maternity building still more homelike, we provide throw rugs of a washable material.

In planning the decoration of rooms in the guest suite we employed the same methods as for patients' rooms, with comfort and attractiveness as the keynote. Delightful low beds, colorful cretonnes in red, green and yellow tones on a tan background, plain and printed bedspreads with flounces on both sides in the same material, or in plain colored percale, with harmonizing colored bindings give these rooms a smart and charming appearance. Nonskid scatter rugs are used in soft blue, green and brown tones over gray linoleum. A beautiful tan blanket with brown silk binding and "Guest Suite" embroidered in one corner adds to the dignity and attractiveness of the room.

There is satisfaction in a room that has personality and charm, that creates a desire to stay and to come again. Such rooms can be had and should be provided in every hospital.

quist, superintendent of Sherman Hospital, Elgin, Ill., presiding. These are: (1) handling and supervising wall washing and painting; (2) creating interest in work and cooperation among housekeeping employees; (3) granting special privileges to em-



Mrs. Alta LaBelle

ployees in good standing, and (4) controlling waste and extravagance in the use of supplies.

The second day's papers will present the views of two leading Chicago hospital housekeepers: Mrs. Alta M. LaBelle of Michael Reese on "Does the Architect Consult the Housekeeper?" and Mary Anderson of Provident on "Window Washing Statistics." Open discussion will follow.

On the final afternoon Gladys Brandt, R.N., superintendent of Cass County Hospital, Logansport, Ind., will be round table chairman, assigning twenty minutes for discussion to each of the following topics: (1) fundamental duties of hospital housekeepers; (2) rugs, their use and care in patients' rooms, and (3) upholstered (fabric or leather) chairs in patients' rooms. It sounds as if three profitable afternoons were in store for executives in the housekeeping field.

THE HOUSEKEEPER'S CORNER

• Plans advance apace for the NEHA congress to be held in Cleveland, May 20 to 23, with headquarters at the Hollenden Hotel. A highlight for hospital members will be a talk by Dr. James A. Hamilton, superintendent of Cleveland City Hospital.

May 20 has been designated Official Hospital Day and the chairman for the day will be Mrs. Doris Dungan of West Jersey Hospital, Camden, N. J., who will be assisted by Mrs. Lillian Jacques, Newton Hospital, Newton Lower Falls, Mass.

For that day, trips have been arranged through the Western Reserve University Hospitals and St. Luke's Hospital, where there will be a reception and tea, with Mrs. Martha Wodehouse, vice president of the Cleveland chapter as hostess.

Problems that confront both hospital and hotel housekeepers have been welded together in the program in a constructive way, and among the events planned is a trip through the famous Nela Park, with a lecture on lighting problems which should be of interest to all.

Each evening there will be some gala affair, to be climaxed by a dinner

dance on Saturday evening at the Hollenden Hotel. General chairman for the congress will be Mrs. Adele B. Frey, first national vice president, who will also be hostess to the delegates. Theodore DeWitt of the DeWitt Hotels has graciously provided rooms for all members of the association, regardless of whether they are engaged in hotel, hospital or club work.

A national hook-up radio broadcast is to be arranged for either Friday or Saturday.

• One of the big regional hospital gatherings is the annual Tri-State (Indiana, Illinois, Wisconsin) meeting held in Chicago. This year for the second time a housekeepers' section has a place on the three-day program. Mrs. Alta LaBelle, Michael Reese Hospital, Chicago, is chairman of the section. On the opening afternoon, May 5, Mrs. Emma Boyer Mercer, executive housekeeper, Methodist Episcopal Hospital, Fort Wayne, Ind., will present a paper on wall washing and painting.

Four good discussion topics have been assigned for that afternoon's round table, with Charles A. Lind-

• "Housekeeping on Parade," a book of practical ideas for housekeepers in hotels, hospitals, clubs, institutions, compiled from articles published in the *Hotel Monthly*, has just been published by the Hotel Monthly Press, and every housekeeper will undoubtedly want a copy for her library. In story and picture it tells much of the "how" of the housekeeper's job. Leading hotel and hospital housekeepers have contributed from their storehouse of knowledge to make the book a guide on various phases of executive housekeeping. Subjects discussed include: Linens—What to Buy and Why; Instructions to Maids; Systematic Cleaning; Furniture Finishing and Retouching; the Executive Housekeeper; Records; Housekeeper Charts. The price is one dollar.

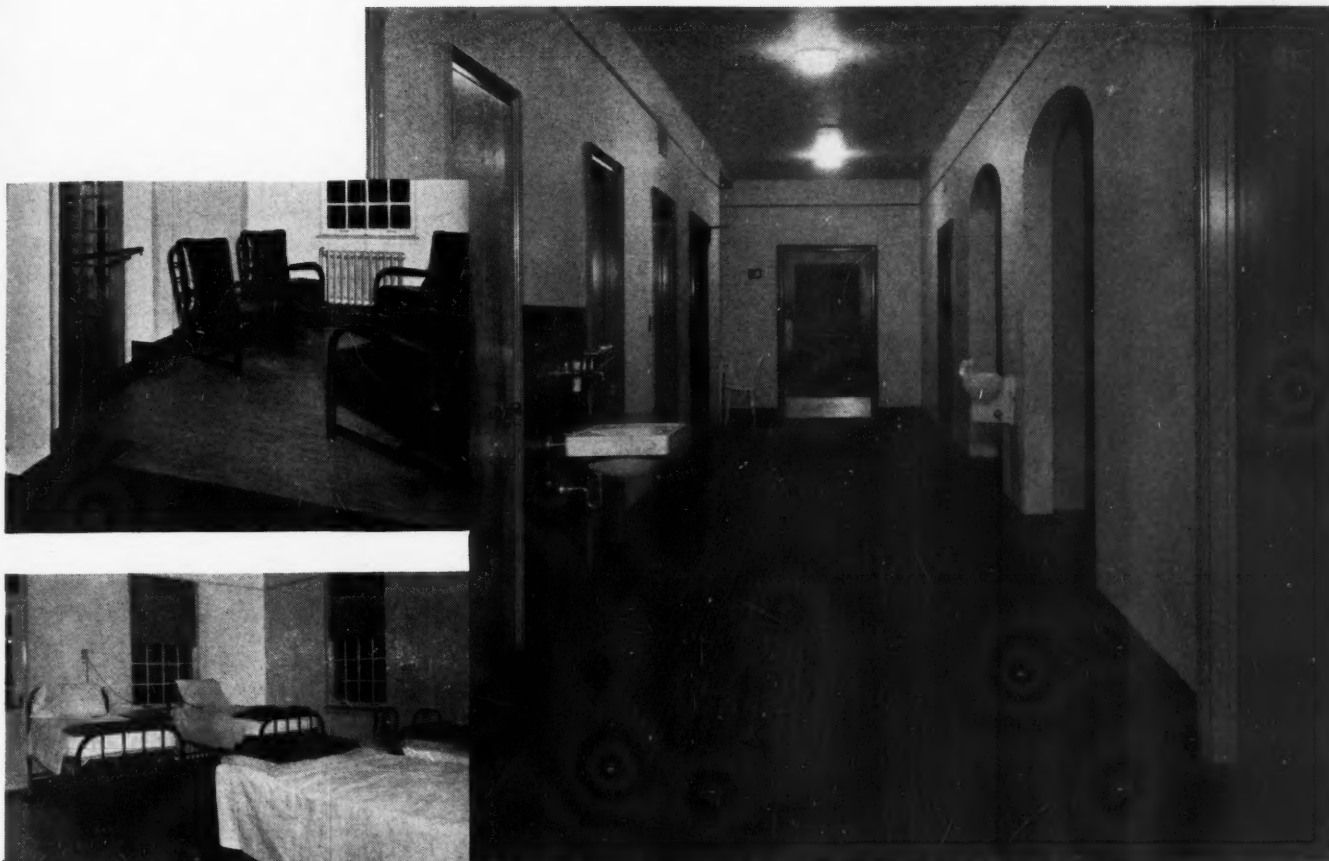
• Friends of Mrs. Anna Haywood, executive housekeeper for several years at St. John's Riverside Hospital, Yonkers, N. Y., will be interested to learn that she is now director of housekeeping at Beth Israel Hospital, New York. Her post at St. John's has been filled by Miss E. M. Messing.

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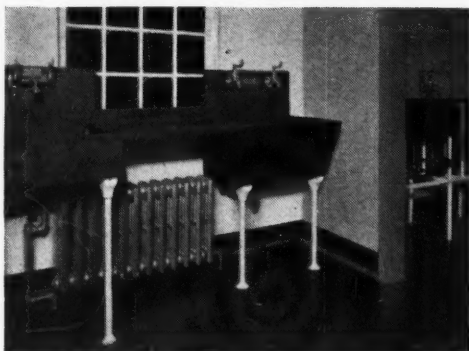
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FOOD SERVICE

Conducted by Anna E. Boller, Rush Medical College

Centralized Dishwashing Wins Approval

By Virginia H. Ray

IN PLANNING details of a dietary department consideration must be given to the physical structure of the plant, the quality of service demanded, the volume to be produced within a given time, the personnel to carry on this work and above all the cooperation which may be counted upon from other departments. Thought must be given, as well, to future expansion.

In 1928, Albany Hospital, Albany, N. Y., opened a modern eight-story, private pavilion upon the site previously occupied by the administration wing of its rambling two-story structure. Prior to this time, food prepared in quantity in the main kitchen had been dispatched in bulk to the ward pantries from which patients' trays had been served. In the interests of economy and improved quality this method was abandoned.

The old kitchen was discarded and a new kitchen with auxiliary preparation units was built in the basement of the new building. Grouped about

and adjacent to this kitchen were five central tray serving stations to which food prepared in small quantities, by skilled cooks, could be kept moving throughout the serving period, and from which trays could be dispatched upon eight high-speed electric lifts to all patients upon the six floors above.

These lifts, carrying six trays each, travel at the rate of one story in five seconds ensuring hot food with a minimum expenditure of employees' time. A description of this has been published elsewhere.¹ Originally soiled trays were returned via the same lifts to the stations from which they had been served. Here they were dismantled, dishes scraped, racked and washed in dishwashers having a 5,000 per hour capacity.

Obviously the defect in this system was the dispatch and return of trays over a single line. After leaving the

¹ Ray, Virginia H.: Central Food Service in the Albany Hospital, J. Am. Diet. A. 5: 3 (Dec.) 1929.

patient, soiled trays should have proceeded forward to some central point, avoiding traffic jams and delays which occurred when the dispatching of nourishments and late trays interrupted the return of soiled trays.

To this central point soiled trays placed upon tray carriers could be transported by elevator and from this point clean dishes could be trucked to the various serving stations. Similarly, from dining rooms, soiled dishes carried on trays to the pantries for scraping and washing, could be placed, instead, in neat stainless steel boxes wheeled upon a small truck directly to the dishwashing room, there to be scraped, racked and washed. Clean dishes would be returned in the clean boxes.

The central dishroom was visualized with a layout of the factory type, using a roller conveyer for transporting dishes, this conveyer to be arranged in a circle or square to avoid break in line of traffic and to make it possible for a single employee, standing in the center, to reach each section with a minimum of steps.

The layout had to be capable of expansion to accommodate at least twice the present capacity, by increasing the number of employees with no change in equipment. In addition to a large automatic dishwasher, equipment was to include a glass washer and silver burnishers.

Washing must be thermostatically controlled at a low temperature, rinsing similarly controlled at a high temperature and a steam spray provided both for sterilization and for speeding up the drying process. Because of



Scene in the central dish washing room—soiled dishes are in the foreground, the glass washer is on the left and the terminus of the gravity roller conveyer at the left rear.

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Recipes without
4 tablespoons sugar
Cinnamon Toast
4 Ry-Krisp wafers
2 teaspoons cinnamon
Mix sugar and cinnamon together. Brush Ry-Krisp wafers with vegetable oil or shortening and bake in a moderate oven (200° F.) until brown. Sprinkle on sugar mixture while warm.
Gravy.

WHEAT, EGGS OR
4, cup Ry-Krisp flour
1 tablespoon vegetable oil
Ry-Krisp

SPECIAL RECIPES AND FOOD LISTS
for
Wheat, Egg, and Milk-Free Diets
(FIFTH EDITION)

IF YOU GAVE
Each Patient
HALF A DAY
You Might Just Cover What
This Booklet Covers For You

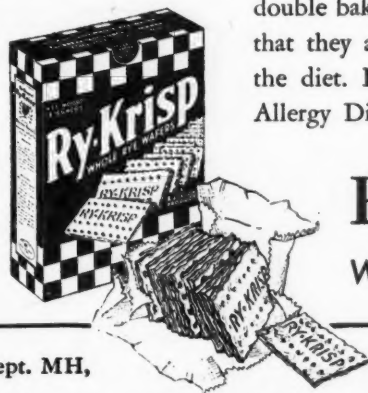
WHEN a patient is sensitive to such common foods as wheat, milk or eggs, the task of explaining the necessary diet is a tedious one. And all the "musts" and "don'ts" at once are apt to be confusing.

Why not take a simpler way that's really better for your patient and for you? Just hand him a copy of this booklet—marking the section which applies to his particular sensitivity. There, plainly stated for easy and repeated reference, are exactly the foods he may or may not have—and even suggestions for safe and tempting recipes to enhance restricted menus.

You can distribute this booklet with perfect confidence. It is approved and used by many leading allergists, in private practice and allergy clinics. With the direction

and assistance of recognized authorities, it was prepared in our laboratories, where years have been devoted to research and the study of allergy problems. These booklets are for professional use only. None are distributed to the laity.

Notice, when you examine this booklet, how frequently Ry-Krisp appears in the lists of accepted foods. That's because these tempting and delicious wafers are simply made of flaked whole rye, salt and water, double baked. They're perfectly safe—so inviting that they actually encourage closer adherence to the diet. For free samples and copies of the Allergy Diet Booklet, use the coupon.



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Without obligation, please send me samples of Ry-Krisp and Allergy Diet Booklet

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The soiled dish table is in the foreground, the dish washer, in the right center, and the glass washer, in the left center.

endurance and ease in cleaning, stainless steel was the material desired.

Many difficulties lay in the path of securing such a plant, the three outstanding ones being lack of space, the need for additional transportation and the securing of necessary funds.

Fortunately the interest and cooperation of a kitchen equipment engineer with the imagination and technical skill to work out these suggestions was secured. We are happy to acknowledge our indebtedness to J. Fred Lewis of Albany, who translated these ideas first into blueprints and later into the present complete plant.

To obtain funds it was necessary to submit plans with costs, together with conclusive proof that the economies to be realized, would not only pay interest upon the investment but would amortize the original fund within a reasonable period. Had a similar plant been in existence, the burden of proof would have been lightened.

Pavilion C lies midway between the nurses' home and the hospital elevators, and by establishing the plant in the basement of this wing, transportation would be minimized. The space, however, seemed both undesirable and unobtainable. The ceiling was less than 6 feet high and was diagonally crossed with a meshwork of water, steam and waste pipes. Beneath a steeply ramped floor, lay the main sewer lines. The wing itself was partitioned off into numerous storage closets, belonging to other departments which generously sacrificed these to the dietary department.

Removal of the partitions left a space broken at frequent intervals by steel columns supporting the building. Since these could not be moved, all equipment had to be so designed that these columns would not interfere with operations. To obtain necessary head room and remove part of the objectionable ramp, the floor had to be excavated. This in turn meant that

each steel column supporting the building must be extended 36 inches, a feat which was accomplished by inserting beneath each steel column a 60-ton jack while constructing a new form for the cement supporting pier into which the column was set.

A smooth concrete floor was laid over the entire space, adequate grading and good drainage being provided to facilitate frequent hosing. The ceiling was soundproofed, ventilation was provided by use of two exhaust fans with sufficient capacity to change the air in the room every three minutes.

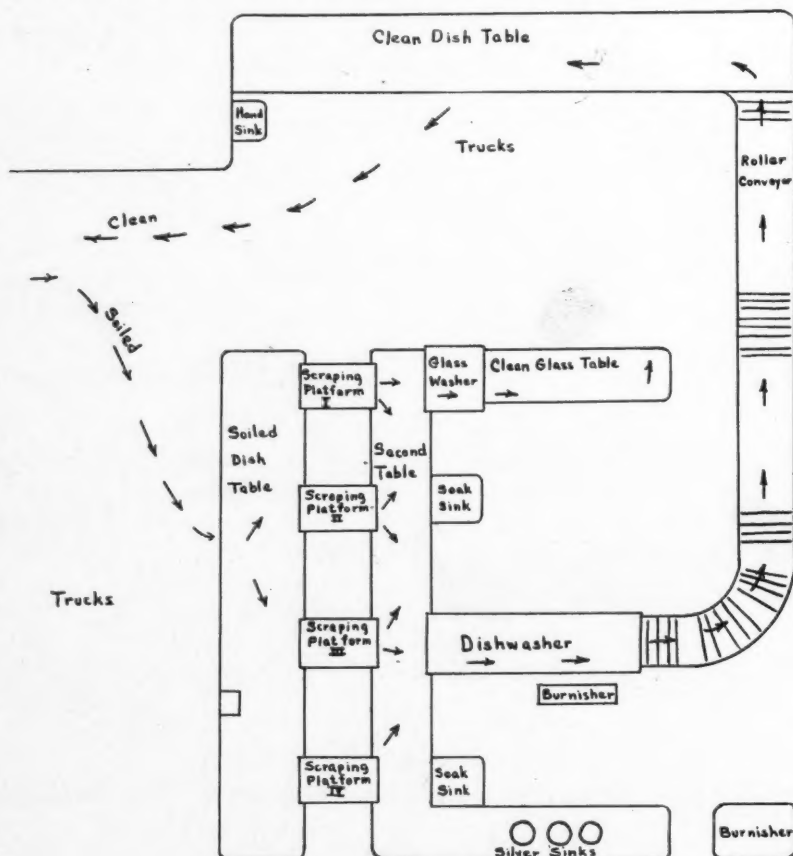
Careful attention was given to proper lighting.

Soiled dish trucks enter this room from the northeast corner and are placed along the north wall. Extending parallel to this wall is the receiving table, 20 feet long, on which soiled trays from the trucks are unloaded. Parallel to this table and of equal length is a second table from which the glass washing and dishwashing machines extend at right angles.

Between these two parallel tables stand the dishscrapers, each of whom has directly before him a sliding platform shelf of stainless steel extending from one table to the other. On this platform shelf is placed an empty dishrack. Within easy reach of each worker upon a shelf over the receiving table are other racks, one for silver, one for glassware, one for cups. This makes it possible for a scraper as he strips each tray, to rack every piece without leaving his position.

As a rack is filled it is pushed along the second table toward either the glass machine or the dish machine. The filled rack is immediately replaced by an empty one, which the scraper, without leaving his position, picks up from the roller conveyor for the return of clean racks extending along the under side of the soiled dish table. As trays are emptied they are racked, seven at a time, and dispatched through the dish machine.

At the east end of the soiled dish table and at right angles to it extends

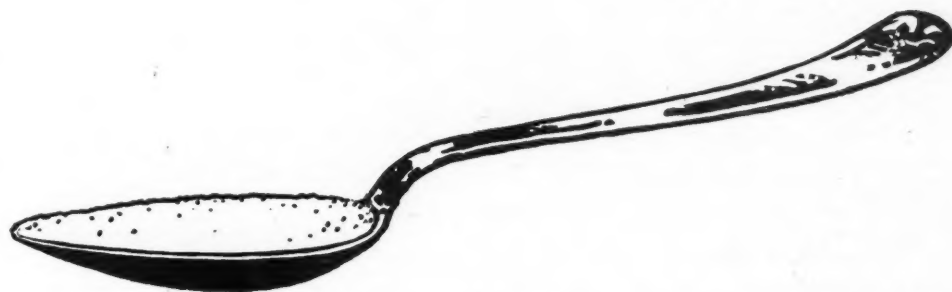


Layout of the dish washing room.

THINK OF THIS!



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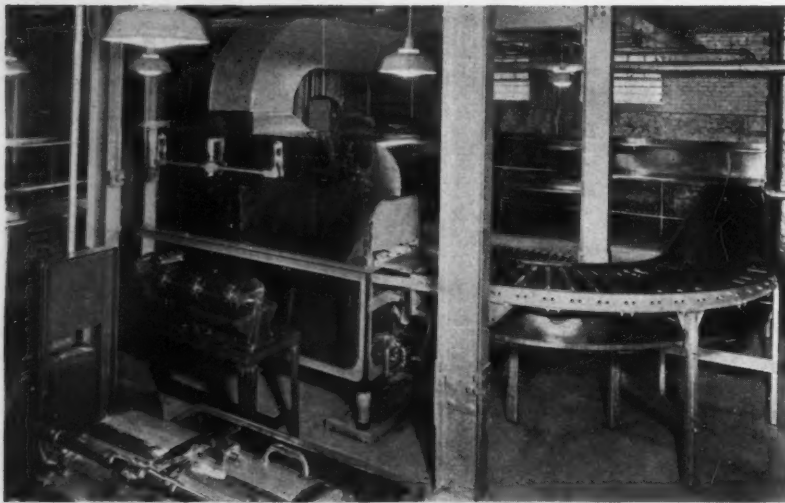


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★ Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.

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The dishwasher and gravity conveyer.

the glass machine capable of handling 6,000 glasses an hour. This opens upon a clean glass table 8 feet long having an overhead shelf for stacking dry glassware. The clean glass table is parallel to and within reach of the clean dish table, 20 feet long extending along the east wall of the room. One worker standing between these two tables can readily sort and load for return all clean glassware, dishes, silver and trays.

A careful study was made of the various types of dishwashing machines before selection was made of the double tank, dual motor, basket conveyor type, with a capacity of 18,000 pieces an hour. Unquestionably this is less dramatic in appearance than the conveyor belt machine. The speed of the latter, however, is limited to the number of workers who can come within loading distance of the machine, whereas, with the basket type the speed and volume can be increased indefinitely by increasing the number of workers filling baskets.

As previously stated this machine extends at right angles to the soiled dish table. It is, therefore, parallel to, but as far as practical from the clean dish table. From this machine to the clean dish table extends a roller conveyer 24 feet long. This conveyer carries the racks of washed dishes, silver, trays, from the machine to the clean dish table negotiating a right angle turn during the trip. Incidentally, to ensure this right angle turn together with slope sufficient to propel with safety the racked dishes was a nice engineering problem.

During this trip the dishes dry. They are inspected, sorted, stacked, the empty rack being returned to the scrapers by the previously described conveyer along the soiled dish table.

During inspection tarnished silver is removed for detarnishing and polishing and the occasional stained cup or saucer set aside to be dipped in javelle water which we have found efficacious in removing stains without the trouble

of hand scouring. Clean trucks are loaded with complete service before being dispatched to their respective stations.

The problem of returning clean dishes was the most difficult one we encountered and was complicated by the fact that the entire hospital, both patients and personnel, use dishes identical in pattern. The dishroom is given the daily census for each serving unit so that the division may be approximated.

To simplify counting, all dishes are stacked to a standard height and cups so arranged that each tray holds five dozen. We believe that in any institution where dishes must be dispatched to a large number of distant points this problem of sorting and transporting clean dishes would be so great as to render central dishwashing impractical.

In this sketch of the general layout of the plant, no mention has been made of those nice details which make it a source of pride to our workers.

First of these are the tray trucks. Of the several we have tried, the most practical for patients' trays have six shelves, each shelf holding three trays. Larger trucks we found unwieldy, smaller trucks necessitated too many trips. To prevent dishes sliding off when trucks are wheeled over ramps, a guard rail was built about three sides of each shelf. Each truck has two movable and two stationary wheels. All trucks are equipped with rubber bumpers.

For the dining rooms, the dish boxes of stainless steel are 22 inches long, 12 inches wide and 8 inches deep and have comfortable handles at either end. Trucks with three shelves, each shelf holding three baskets, transport both unscrapped and clean dishes.

In the dishroom all equipment is of stainless steel with rolled edges. Double removable drains have been built into the receiving and soiled dish tables. At various points along the receiving table where scrapers are

stationed, cut-outs are located through which refuse is scraped into the garbage cans beneath. Removable rubber rings, too small to admit pieces of silver, fit into each cut-out.

The glass washing machine and both tanks of the dishwashing machine are fitted with thermometers, one for the wash kept at 120° F. and one for the rinse at 180° F., with temperature thermostatically controlled. On the dish machine a special mixing valve provides for a final rinse of steam and water.

To make rapid inspection of clean dishes and glasses possible, overhead shelves have been fitted with indirect lighting.

A large and a small silver burnisher, recommended with some misgivings, since we had received such conflicting reports regarding their value, have proved worth while purchases.

We find these equally satisfactory for burnishing silver, nickel silver and aluminum. A section of the soiled dish table, with three circular inset sinks fitted with metal dipping-baskets for detarnishing silver, extends along the west wall at the rear of the dish machine. Burnishers are loaded many times during the dishwashing period, the operator being free for other duties while these are running.

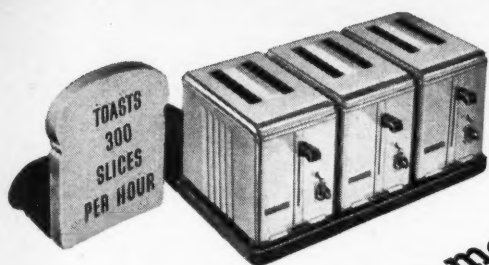
One soak sink has been located near the dish machine, a second near the glass machine. A small sink for cleaning carts is set in the receiving table. To these we added a hand sink near the clean dish tables. Incidentally, should a severe storm disable our power lines, this equipment would be adequate for dishwashing by hand. With such a possibility in mind, one silver sink was equipped with a steam spray for sterilization.

No description of the plant would be complete without a word about the crew who man it. Since dishwashing was formerly done by station maids, the installation of this plant meant a drastic reduction in their numbers and a partial replacement by men.

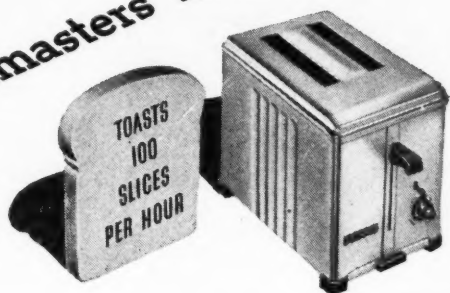
Hiring Help

When the project was approved, we resolved to avoid unhappy situations by engaging, whenever a vacancy occurred in the department, a young man suitable for dishroom work. Since the worker engaged was not always suitable for the position vacated, some shifting about of personnel was necessary. Each new employee was informed that his work was temporary but that a certain number would be retained for the dishroom then being built. When the room was completed we had our picked crew, and from this group we had selected their leader.

During the preceding weeks the dishroom, its layout, its cost and what we hoped it would accomplish had been discussed with these workers,



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Thermotainer Food Warmers
Roll Warmers • Cafeteria Units • Waffle Bakers

NEW TOASTMASTER *Toaster*

MAKES MOST OF THE WORLD'S TOAST

who watched its construction eagerly. The enthusiasm they developed carried us through the first week, during which routine methods and team work became established. At first only patients' dishes were cared for. As skill and speed developed, dishes from the various dining rooms were absorbed without additional employees and working hours were gradually reduced.

All the structural changes in the building and equipment installation were carried out by the hospital mechanical department, under the direction of E. W. Jones, director of the hospital; G. R. Studebaker, assistant director, and George Behm, master mechanic.

Thorough and systematic planning in the blueprint stage, and frequent conferences between the hospital administrative authorities, Mr. Lewis, and engineers from the equipment manufacturers were rewarded by a plant which functioned from its first day of operation with a minimum of trouble.

Central dishwashing has proved of value at the Albany Hospital, not only by improving service but by decreasing costs. Improvements in service include:

1. Relegating to an isolated section of the basement the noise and unsightliness attendant upon the scraping and washing of dishes.

2. Improved sanitation through having preparation and serving units free from contamination by soiled trays.

3. Providing for sterilization of trays each meal, as well as of dishes and silver.

4. Eliminating delays in serving late trays and nourishments caused by reverse traffic on dumb-waiters.

5. Simplifying checking of waste by concentrating this in one room.

6. Providing in each serving unit additional space for expansion to serve an ever increasing clientele.

Economies have resulted as follows:

1. Reduction in labor; estimated at \$4,100 a year, four months' actual operation shows saving on a basis of \$4,500 a year.

2. Formerly five machines were manned as against one with the new plant.

3. Hand toweling of dishes and glass has been eliminated.

4. Hand polishing of silver has been eliminated.

5. Division of labor into two groups, one for serving, one for dishwashing, has resulted in improving the skill, speed and contentment of each group.

6. Reduction in supplies: estimated reduction in breakage of china and glassware of \$1,000 a year; tea towels together with laundering; cleaning materials; maintenance cost.

The complete installation cost was \$15,500, of which \$11,000 was for equipment and \$4,500 for labor.

A Dietitian to the Rescue

By Margaret B. West

FOR the past several weeks the American Red Cross has been caring for nearly one thousand white flood refugees and a large number of colored people in tent cities on the edge of Anna, Ill.

The arrival of these crowds of refugees presented quite a problem to the residents, who were willing and eager to do anything possible to help. Buses, trucks, passenger trains and freight cars were pouring into Anna, each carrying as many people as could be possibly crowded into the conveyance. Anna's population had almost doubled overnight.

All the men who were able to work

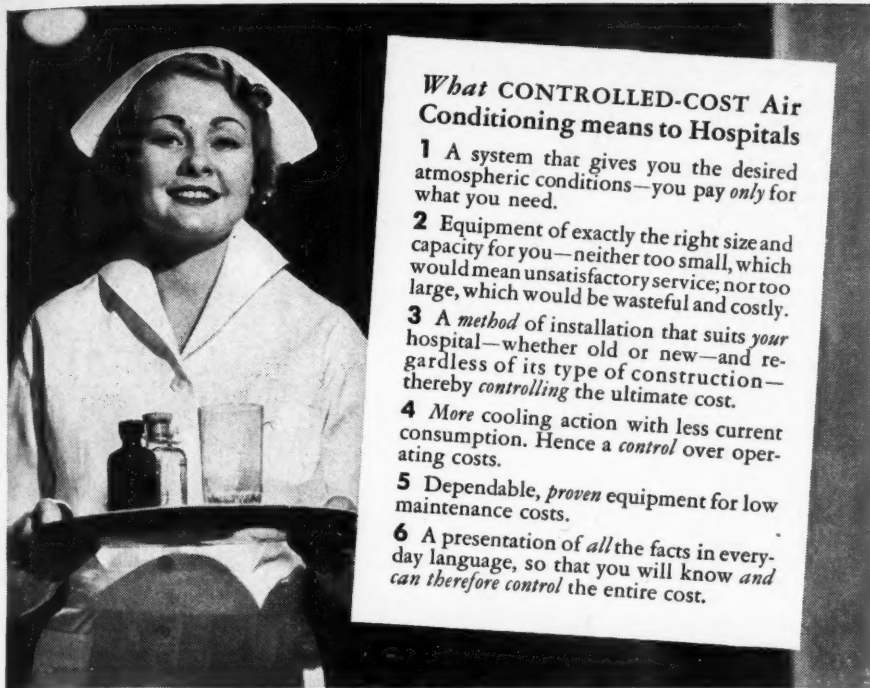
had been sent to help build up the levee at Cairo. Four thousand men worked there day and night, strengthening it to prevent further disaster.

It was a heart-breaking sight, watching homeless and hungry women, children and old people arrive, carrying their pitiful little bundles of clothing and bedding.

Shelter was found for the entire crowd. They were very quiet, and accepted gratefully any means of housing offered them. They were sent to churches, homes, schoolhouses, lodge halls and vacant buildings of all types. In the first rush, families were separated and scattered in every direction.

MENUS BASED ON DAILY FOOD REQUIREMENTS

Breakfast	Dinner	Supper
MONDAY		
Stewed figs	Boiled beef	Buttered hominy
Oatmeal	Noodles	Applesauce
Bread Butter	Buttered green beans	Scrambled eggs
Coffee	Bread Butter	Bread Butter
	Coffee Milk	Cocoa
TUESDAY		
Stewed prunes	Beef stew	Buttered cabbage
Farina	Potatoes, carrots,	Macaroni and cheese
1 soft boiled egg	onions and tomatoes	Peaches (stewed)
Bread Butter	Apricot bread pudding	Bread Butter
Coffee	Bread Butter	Coffee Milk
	Coffee Milk	
WEDNESDAY		
Stewed apricots	Franks	Spaghetti and tomatoes
Cracked wheat	Seasoned pinto beans	Buttered corn
Bread Butter	Rice and raisin pudding	Cheese cubes
Coffee	Bread Butter	Bread Butter
	Coffee Milk	Cocoa
THURSDAY		
1 cup tomato juice	Roast beef with gravy	Creamed potatoes
1 boiled egg	Dressing (onions)	Bologna
Oatmeal	Green beans	Peach sauce
Bread Butter	Bread Butter	Bread Butter
Coffee	Coffee Milk	Cocoa
FRIDAY		
Stewed prunes	Baked macaroni	Scrambled eggs
Farina	and cheese	Green beans
Bread Butter	Buttered peas	Raisin bread pudding
Coffee	Escalloped tomatoes	Bread Butter
	Bread Butter	Coffee Milk
	Coffee Milk	
SATURDAY		
1 cup tomato juice	Hamburger and	Baked beans
Oatmeal	spaghetti	Creamed onions
1 boiled egg	5-minute cabbage	Stewed prunes
Bread Butter	Buttered carrots	Bread Butter
Coffee	Bread Butter	Coffee Milk
	Coffee Milk	
SUNDAY		
½ orange	Roast beef with gravy	Hominy grits
Farina	Seasoned potatoes	Stewed apricots
1 soft boiled egg	Buttered peas	Bread Butter
Bread Butter	1 cookie	Milk or Cocoa
Coffee	Bread Butter	Coffee
	Coffee Milk	



What CONTROLLED-COST Air Conditioning means to Hospitals

- 1 A system that gives you the desired atmospheric conditions—you pay *only* for what you need.
- 2 Equipment of exactly the right size and capacity for you—neither too small, which would mean unsatisfactory service; nor too large, which would be wasteful and costly.
- 3 A *method* of installation that suits *your* hospital—whether old or new—and regardless of its type of construction—thereby *controlling* the ultimate cost.
- 4 *More* cooling action with less current consumption. Hence a *control* over operating costs.
- 5 Dependable, *proven* equipment for low maintenance costs.
- 6 A presentation of *all* the facts in everyday language, so that you will know *and can therefore control* the entire cost.

Controlled-Cost AIR CONDITIONING

Brings to Hospitals a practical, business-like way of controlling cooling costs

Frigidaire *Controlled-Cost* Air Conditioning is used in far more hospitals than conditioning equipment of any other kind . . . *because* it meets certain definite requirements of hospital work.

It supplies everything from the simple, inexpensive *cooling* of rooms to the most elaborate *conditioning* of operating rooms and laboratories. And you can start with as little or as much equipment as you please and add to your installation room by room—department by department—at any time.

Further, *Controlled-Cost* Air Conditioning is a boon to the hospital bud-

get. It not only costs less to own, but—by presenting *all the facts* in advance—in other words, by clearing up the “mystery” of air conditioning—it lets you know *and therefore control* the entire cost.

In hospitals throughout the country Frigidaire *Controlled-Cost* Air Conditioning is aiding the recovery of patients, bringing cool comfort to harassed nurses and doctors, relieving hay-fever, improving operating room and dressing room efficiency . . . and repaying its entire cost by attracting patients who are willing and glad to pay more

What Hospitals say about

FRIGIDAIRE

Air Conditioning

“We do feel that we have received greater profundity of anesthesia since conditioning our operating room, due to the fact that the patients do not perspire so freely, a condition which tends to add to the shock of a patient.”

—Norfolk Protestant Hospital
Norfolk, Virginia

“Our Delco-Frigidaire air conditioning which you installed in our Surgical Department has been working satisfactorily. We shall be glad to refer any prospective customers to you, and incidentally, speak a good word in behalf of the system.”

—Mt. Carmel Hospital
Columbus, Ohio

“Our air conditioning in the delivery rooms and in the four operating rooms has been ideal after the machines were properly adjusted. The operating expense is small, and it gives intense satisfaction to the patients, surgeons and nurses.”

—The Crawford W. Long
Memorial Hospital
Atlanta, Ga.

“Since May 15th, 1935, which was the date we completed installation, we have operated on one hundred and one children. We thoroughly enjoyed our work this summer. Our operating room has a western exposure and in the afternoons it is impossible to stay in the room, much less work in it, but this summer we operated the entire day, and did not feel the heat at all.”

—Kosair Crippled Children's Hospital
Louisville, Ky.

for cool comfort during the hot days of summer.

Get all the facts about Frigidaire *Controlled-Cost* Air Conditioning for hospitals . . . and for *your* hospital in particular. Mail the coupon below . . . *Today*. It places you, of course, under no obligation whatsoever.

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I want the facts about *Controlled-Cost* Air Conditioning. Please send me the complete story by return mail. I am obligating myself in no way at all.

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It Pays to Talk to DELCO-FRIGIDAIRE

The Air Conditioning Division of General Motors

AUTOMATIC COOLING, HEATING AND CONDITIONING OF AIR

The housing problem settled, the next problem of paramount importance was how to feed these people. For the first ten days the U. S. Army lent assistance and provided cooks; after the army cooks were withdrawn, CCC cooks substituted. With such a large number of persons to house and feed, it was inevitable that problems of health and sanitation would arise, and the state hospital was called upon for aid and advice in the emergency. Dr. R. A. Goodner, the managing officer, offered my services, in connection with solving the food service problem.

We considered the feeding problem from every angle. It had been suggested that the hospital lend cooking utensils to the Red Cross workers, who would prepare the food wherever it was most convenient to do so. However, it would have been an endless task for the women to supply food in such large quantities when space was so limited, and it was difficult to obtain sufficient food or stoves on which to cook it. Also there would be the problem of keeping track of the hospital's equipment, and collecting it after the emergency was over.

Doctor Goodner suggested the use of the old canning kitchen in the hospital for the preparation of food, and for one week all food for 1,500 refugees was cooked in this kitchen by cooks and helpers supplied by the Red Cross and WPA.

The mayor of Anna told me that he would get me anything I wanted so I asked for ten WPA women; twenty-four ten-gallon milk cans, one truck and a driver. With this equipment, we took care of the refugees housed in schoolhouses and churches where there was no possible way to prepare the necessary food.

In planning my menus, I had to consider that the food would be served from the ten-gallon milk cans, that there were no tables for people to sit at and no knives and forks. Tin pie pans, tin cups and spoons were obtained for all, and in addition enough soup bowls, plates and coffee cups for 500.

CCC Camps Utilized

After the first week, the CCC camps were ready to house the refugees, and also to feed them. It was necessary to erect two camps—one for white people and one for colored. The latter were sent to the camp at Wolf Lake, because Anna does not permit colored people to live in the town.

This solved most of the problem, but I was again called upon to inaugurate a food service for 1,000 white people at a camp at the Fair grounds. The Red Cross furnished all the food, two cooks formerly at the state hospital were placed on the pay roll, and five additional men from Anna were hired to assist in the preparation of the food. A homemade cafeteria was con-

structed of pine boards, and a system was developed whereby 900 could be fed in thirty-five minutes.

A copy of "Food Requirements for Daily Needs" was supplied to every cook in the camps at Anna and the

surrounding Southern Illinois towns. The accompanying menus, based on these requirements, were planned around the food obtainable, taking into consideration the equipment for cooking, serving and eating it.

Memories of Florence Nightingale

WITH the approach of National Hospital Day, it seems appropriate to consider briefly one of the best known women in the hospital field. Florence Nightingale has been called the standard-bearer of the nursing profession, and she might well be called the standard-bearer of the dietetic profession as well. She was intensely interested in nursing as a young girl, and in the face of her parents' disapproval, spent two years in a hospital at Kaiserwerth, Germany, where our present system of nursing was founded.

In 1854 at the time of the Crimean War she saw her opportunity and grasped it. The condition of the sick and wounded was a national disgrace, and at the request of Queen Victoria, Miss Nightingale assembled a group of thirty-eight nurses and left for the battlefields. The hospital to which she was assigned was alive with rats and vermin, the beds were of straw, laid on the floor and covered with canvas. There was no laundry, no hospital clothing and the food was unspeakable. Miss Nightingale's first request was for 200 scrubbing brushes.

Within ten days after she had landed she had a kitchen fitted up for



Chef Soyer

special diets, which supplied nourishment for nearly one thousand men.

With the assistance of Alexis Soyer, the famous French chef, she began the improvement of the food service, and the establishment of a diet kitchen from which, within ten days, nearly 1,000 men were being fed. Soyer, himself, had definite ideas in regard to proper food service. He immediately made three changes in order to make the food itself more palatable. First, the equipment was thoroughly cleaned; second, the type of fuel was changed; third, the soldier cooks were taught how to use recipes. In his own words, in regard to the last: "By my system of diet, every recipe will be printed, framed and hung up in the kitchen, so that any person, even a soldier (provided he can read), will be able of executing them well, as each recipe will be comprised in a few lines." Indeed, Soyer might well be called the first army dietitian, as, according to Miss Nightingale, he "took the soldiers' rations and patients' diets as they were, and converted them into wholesome and agreeable food."

Soyer has written of her: "Her visage as regards expression is very remarkable and one can almost anticipate by it what she is about to say—alternately with matters of the most grave import, a gentle smile passes radiantly over her countenance, thus proving her evenness of temper. At other times, when wit or a pleasantry prevails, the heroine is lost in the happy good-natured smile and you recognize only a charming woman."



Photos Courtesy Arnold Shircliffe

Florence Nightingale, aged thirty.

MODERN RADIO ... 1924!



Are You Putting Up
with "Back-Numbered"

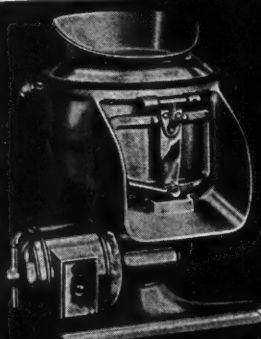
ELECTRIC KITCHEN MACHINES?

MODERN standards of *food quality, sanitation, service and economy* in the hospital—call for MODERN Electrical Food Preparing and Dishwashing Machines! Hobart has developed these machines to *new standards of performance* in 1937 models that "antiquate" hundreds of Dishwashers, Mixers, Peelers, Slicers and Food Cutters of a former day. When you *compare* them—you can see the practical economy of replacing unsatisfactory equipment now.

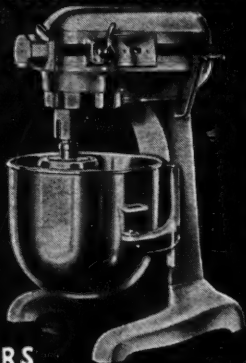
There's a new Bench Type Mixer

(and general food preparer) with so much *broader range* of duty as to give you "two machines in one"—a real 20-qt. Mixer and a real 12-qt. Mixer. New Dishwashers have much greater capacity in less space. New cost-measuring, sanitary Slicer has Staysharp Stainless Steel knife and many other features. Potato Peelers, Food Cutters and Air Whips give you similar reasons for *checking your food preparing equipment now*, and HOBARTIZING your kitchen. Use the coupon to obtain detailed information.

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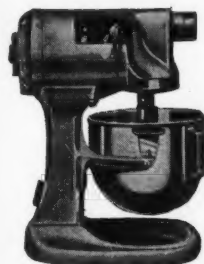
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KitchenAid

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| <input type="checkbox"/> Air Whips | <input type="checkbox"/> KitchenAid (for your Home) |
| <input type="checkbox"/> Food Cutters | |

Name.....

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With a Twist of Paper

THE University Hospitals of Cleveland are fortunate in having in their department of dietetics a woman skilled in the production of favors. Mrs. Caryl Johnston, who manages the service in the doctors' dining room, has for a number of years created special holiday favors for the children, for private patients' trays, for doctors and for guests at special parties.

When the dietitian visiting patients discovers a patient who is celebrating his birthday while in the hospital, she arranges with Mrs. Johnston for a favor to decorate his tray. The perfection with which these favors are made makes them eagerly anticipated. Mrs. Johnston has described for us the process followed in making several of the favors illustrated here.

Doll Bassinets:—The body of the bassinet is formed from a piece of matstock $3\frac{1}{2}$ by $4\frac{1}{2}$ in. Cut a slit $\frac{1}{4}$ in. from each corner, fold into box shape and paste ends together. To cover the box, cut pink or blue crêpe paper 2 in. wide. Put paste around the sides of the box, and gather the paper fully around it. Trim off to about $1\frac{1}{2}$ in.

A piece of paper 3 by 3 in. makes

the hood. Roll one edge between thumb and forefinger, and paste on to the bassinet. Finish off with a beading, made by twisting a $\frac{1}{4}$ -in. strip of paper folded in the center. Paste on wheels about the size of a quarter cut from the matstock. A paper doll lying on a pillow and a fancy cover complete this favor which is particularly suited to the tray of a maternity patient.

Dolls:—Dolls make the most interesting tray favors, and offer the greatest opportunity for diversity and originality. The same principle of construction can be used for all types and sizes, while dress can be entirely a matter of ingenuity.

For the doll's head, use half of a paper napkin rolled tightly into a wad. Cover with white or flesh crêpe paper with the grain of the paper running horizontally, stretch tightly and paste the edges together. Twist the top and bottom of the paper, trimming off the excess at the top but leaving that on the bottom for attachment to the body. Sketch in the features with India ink and tint with water colors if desired.

For the body use a wooden meat skewer pushed into the head. The

Simple to make when you know how, but it takes ingenuity and originality to conceive these tray favors. They were among the amazing array displayed by Mrs. Caryl Johnston at the A. H. A.'s hobby exhibit held at Cleveland

arms are made from a pipe cleaner wrapped around the skewer and the surplus paper at the bottom of the head. They are held in place with strips of narrow paper. Gather on a full ruffle or fringe of paper for the collar, make the hat and cover the skewer with paper. Stick into a gumdrop and put a cigarette in one arm and a place card with the patient's name in the other. Lollipops and candy suckers lend themselves nicely to dolls of this type for the Children's Hospital.

Thanksgiving Turkey:—Even the very ill patient can't resist the beautifully fat turkey gobbler on his Thanksgiving tray. Made from a plump pine cone with a pipe cleaner wrapped about the cone for legs, a stick 2 in. long and the thickness of a pencil for a neck, a head and comb of red sealing wax, and a tail of a few real feathers, this fine fellow actually seems about to gobble up the corn candy in the paper covered soufflé cup in front of him. Both turkey and cup are fastened to a 2-in. square of matstock with transparent tape.

Santa Claus:—Everyone enjoys a roly poly Santa who is also good to eat. A big red apple for a body, arms and legs of plump raisins on skewers, a marshmallow for a head, eyes and nose of cloves and a strip of candied cherry for a mouth, really make a delightful fellow. Give him a red paper cap, marshmallow snow boots and hair, whiskers, belt and tassel of cotton, and he looks ready to be "off to the housetops. . ."

For Better Potatoes

"Why don't my French fried potatoes always turn out well?" a consumer recently asked the Agricultural Adjustment Administration. "I buy carefully and sometimes even store the potatoes in my refrigerator."

Refrigeration may be the secret of the trouble was the answer. Potatoes should be kept out of the refrigerator for best cooking quality. Scientists in the Bureau of Plant Industry, in seeking the solution to a similar problem troubling potato chip manufacturers, found that potatoes stored at temperatures of 60 degrees to 70 degrees yielded good chips, while those stored at lower temperatures were unsatisfactory. These results hold good for French fried and baked potatoes as well as potato chips. Good practice for consumers is to store potatoes at room temperatures, avoiding extremes of hot and cold.

VITAMIN REQUIREMENTS OF MAN

III. VITAMIN A

• The importance and multiple functions of vitamin A in human nutrition are widely dealt with in clinical literature. Xerophthalmia resulting from severe vitamin A deficiency is rare in this country, yet the etiology of many pathogenic conditions, namely, night-blindness, urinary calculi, lesions of the nervous system, impairment of epithelial tissue and subnormal growth, has been linked with chronic avitaminosis A (1).

Minimum human requirements for vitamin A are influenced by such variables as size of the individual and efficiency of absorption. The minimum daily requirement of infants has been estimated at 1500 International units, based upon the vitamin A content of milk. The need for the vitamin is not supplied by 1200 International units, while 2000 International units appear to be sufficient (2).

Although the minimum requirement of the adult has been estimated to be as low as 500 International units, the optimum level for both older children and adults is probably between 3000 and 5000 International units

per day (3). The League of Nations Technical Commission recommends over 5000 International units of vitamin A for the pregnant and for the lactating woman (4).

Since the human requirement is evidently high, it is fortunate that vitamin A and carotene (pro-vitamin A) are more or less widely distributed in natural foods. Outstanding sources are some of the highly pigmented fruits and vegetables—especially the yellow varieties—and also dairy and marine products (5).

These protective foods, preserved by modern commercial canning, are readily available in all parts of the country throughout the year. It has been repeatedly demonstrated that commercially canned foods retain their vitamin A potency to a high degree (6). The vitamin A potencies of certain commercially canned products have been recently reported in International units (7). From these reports it is apparent that commercially canned foods can be relied upon to supply quantities of vitamin A entirely consistent with the vitamin A of the raw product.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) a. 1935. J. Am. Med. Assn. 105, 1608
b. 1936. Ibid. 106, 996

(2) 1934-35. Am. Pub. Health Assn. Year Book, Page 70.

(3) a. 1934. J. Am. Diet. Assn. 10, 296
b. 1936. Indian J. Med. Research 23, 741

(4) 1936. League of Nations Report on Physiological Bases of Nutrition, League of Nations Publication Department, Geneva.

(5) 1933. Chemistry of Food and Nutrition. H. C. Sherman. 4th Ed. Page 364. MacMillan. New York.

(6) a. 1931. J. Nutrition 4, 267
b. 1933. J. Am. Diet. Assn. 9, 295
c. 1936. J. Nutrition 11, 383

(7) a. 1935. J. Home Econ. 27, 658
b. 1933. Georgia Expt. Sta. Bull. No. 177
c. 1936. J. Am. Diet. Assn. 12, 231

This is the twenty-fourth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

Hospital Day Tray



Clam chowder, broiled ham, candied sweet potatoes, green beans, grape-marshmallow-nut salad, with whipped cream, ice cream.—*Mary Edna Golder, chief dietitian, St. Anne's Hospital, Chicago.*

Florence Nightingale Salad



On a base of lettuce place a mixture of equal parts of cottage cheese (dry) and coleslaw. Form a Red Cross out of two pieces of bright strips of pimiento and garnish top or side of salad. Serve with French dressing. This is a simple economical salad; good-looking, symbolic and quickly made; a salad such as Miss Nightingale and her famous Chef Soyer might have prepared from their meager food supplies.—*Arnold Shircliffe, Chicago.*

FOOD FOR THOUGHT

- In most hospitals National Hospital Day is of great importance. It is a time when special trays and decorations are often used. Colored tray cloths add considerably to the festiveness of the day, as do soufflé cases filled with ice cream and decorated with spring flower stickers, such as are put out by the large paper companies.

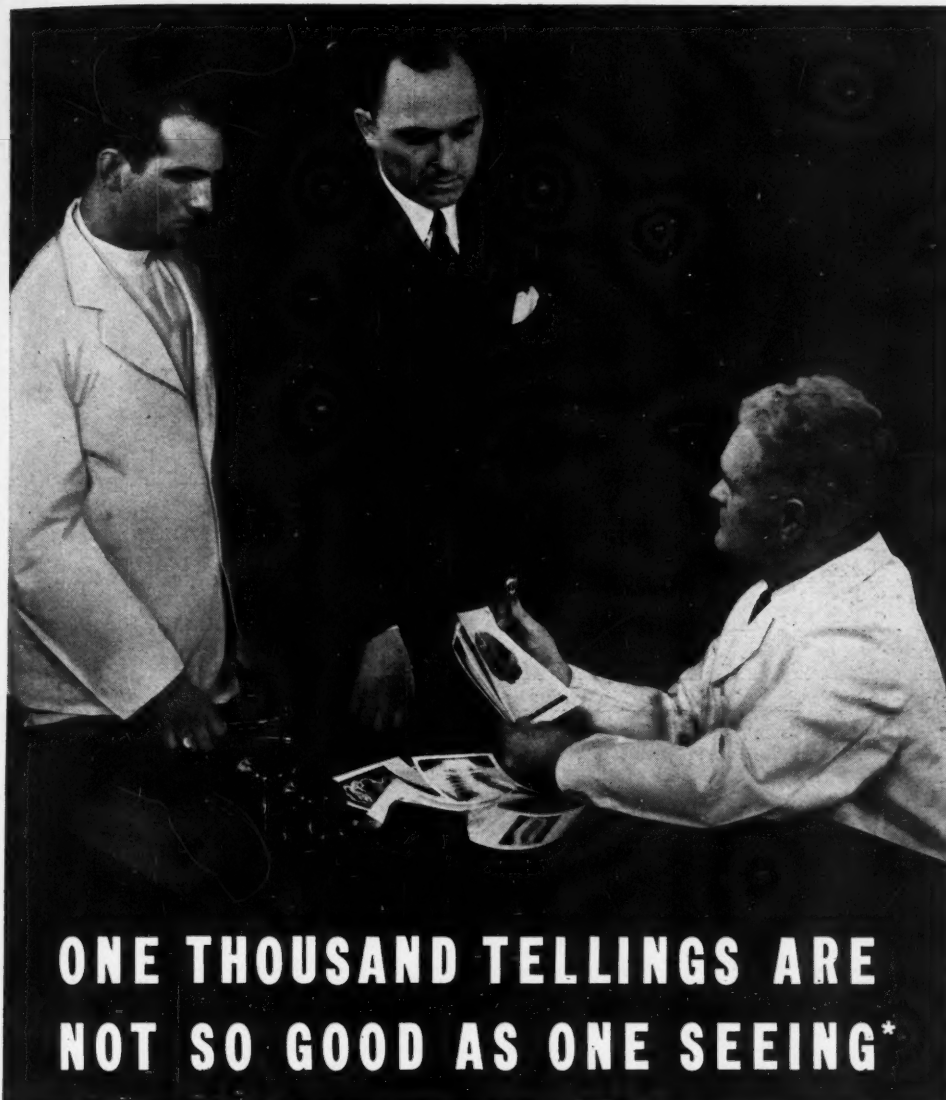
- Decoration Day is also a time for a little extra celebration. The same type of soufflé case can be filled with ice cream and decorated with a patriotic sticker. One that is especially attractive is a child dressed as Uncle Sam carrying an American flag. These can be found either in stickers to be placed on the case, or as little cut-outs on a stem to stick right into the ice cream, or the stickers can be pasted together and stuck on toothpicks.

- Mrs. Frances L. Lawler of Baylor University Hospital, Dallas, Tex., says that almost every day she gets the hospital truck and buys her fruits and vegetables at market. The mild weather in Dallas permits a liberal choice the year round and saves many dollars over buying shipped-in food from wholesale distributors.

- At a faculty clinic at Columbia University school of dental and oral surgery, Dr. Frank E. Beube suggested boiled powdered bone as a remedy for pyorrhea and diseased jaw bones. In experiments conducted by Doctor Beube and Dr. Herbert F. Silvers on dogs, the long bones of sheep and cows were used. Holes were surgically produced in the jaw bone and these were packed with the boiled powdered bone. Within a few weeks new bone, natural cement layer, and other dental tissues had replaced the material lost. One can't help but speculate on the fact that in all probability, feeding this powdered bone would bring about an increase in the calcium and phosphorus of the diet, and give equally satisfactory results.

- Gladys L. Stoddart of University Hospital, Augusta, Ga., writes that this hospital has never handled guest trays except when a patient is very ill and placed upon the critical list. Then a close relative may have a tray. Not over three of these trays were served last year. Visitors are told that they may come to the dining room, or go to the medical school dining room in the next building.

- The bulletin of the Texas State Dietetic Association is rather a pretentious organ for a state group. Those who have not seen it will be most interested. It contains a number of short articles, abstracts and reviews covering nutrition problems, for example, vitamin C in tuberculosis, and loss of protein during fasting. It has a suggestive menu for a holiday, together with recipes.



ONE THOUSAND TELLINGS ARE NOT SO GOOD AS ONE SEEING*

*From a Chinese Guide Book

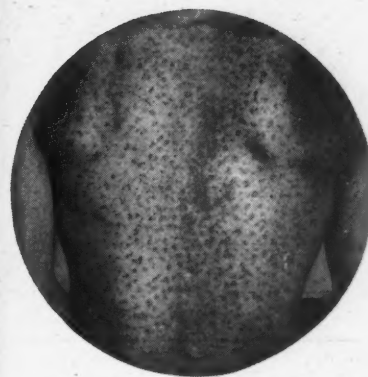
NO mere words nor any amount of written detail could describe the conditions illustrated here as adequately as do these photographs.

The efficient, economical way to provide this service for members of your staff is with a properly equipped photographic department. Then photographic records can be requisitioned as easily as any standard laboratory service. . . Without such facilities, however, the individual physician is thrown on his own resources for photographs.

The applications of photography in medicine are practically unlimited. Il-

lustrations of lesions, abnormalities, operations, gross specimens, before-and-after and progress series, all are important to conferences, lectures, staff meetings, student instruction, published articles, and exhibits. . . They are essential in medicolegal situations.

You can better appreciate the extensive scope of modern photography and the practical necessity of an efficient department from a reading of the new booklet, *Photography in Medicine*, just recently published for this purpose. It is free, and every hospital superintendent should have a copy.



A photograph of a large area of the body in dermatological cases records the distribution of the lesions.



In exhibiting pathological subjects, photographs often may be substituted for the specimens themselves.



Photographs of operations, made from aspects inaccessible to groups of observers, are invaluable in teaching.



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Vol. 48, No. 5, May, 1937

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June Breakfast and Supper Menus

By Angeline Phillips

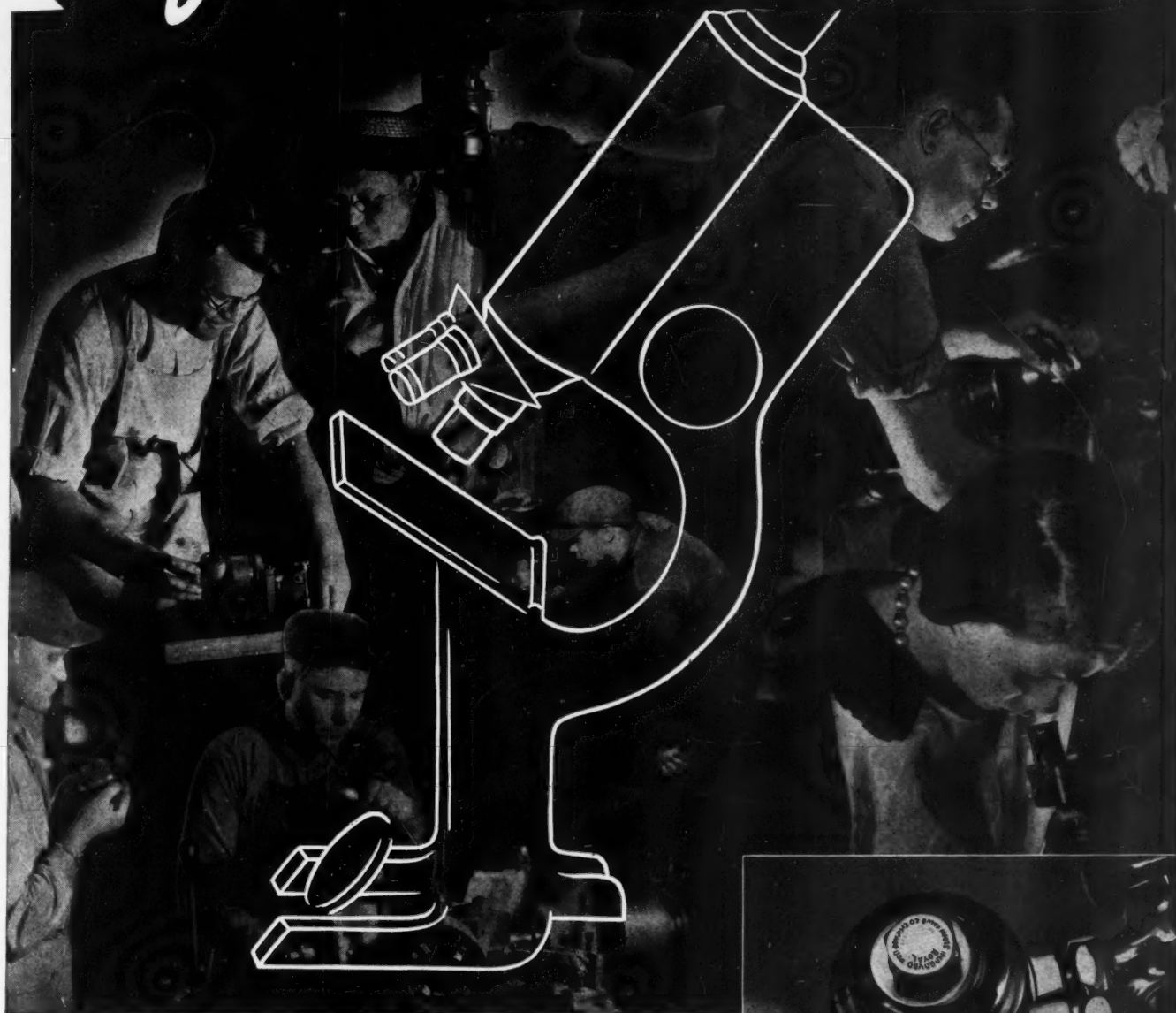
Head, Department of Dietetics, University Hospital, Omaha

BREAKFAST			SUPPER				
Day	Fruit	Main Dish	Main Dish	Potatoes or Substitute	Hot Bread	Salad or Relish	Dessert
1.	Grapefruit	Soft Eggs	Escalloped Salmon		Surprise Muffins	Vegetable Relish	Black Walnut Ice Cream
2.	Pineapple Juice	Chipped Beef on Toast	Canadian Bacon	Spanish Rice		Stuffed Celery Salad, French Dressing	Fruit Compote
3.	Orange	Bacon	Stuffed Eggs in Cheese Sauce on Toast			Cabbage and Carrot Salad	Filled Cookies
4.	Applesauce	French Toast	Vienna Sausage	Corn Pudding		Fresh Asparagus Salad, Russian Dressing	Apricot-Pecan Gelatin Dessert
5.	Baked Rhubarb	Poached Eggs	Tuna Fish Soufflé		Graham Muffins	Vegetable Relish	Red Raspberries
6.	Pineapple Juice	Bacon	Biscuit Meat Roll	Grilled Tomato		Pear and Cream Cheese Salad	Brownies
7.	Grapefruit	Canadian Bacon	Assorted Sandwiches			Fruit Salad, French Dressing	Ice Cream and Macaroons
8.	Orange	Soft Cooked Eggs	Cold Meats	Potato Salad		Dill Pickles	Oatmeal Cookies
9.	Stewed Prunes	Chipped Beef on Toast	Italian Spaghetti With Meat Balls		Cinnamon Rolls	Coleslaw	Snow Pudding, Custard Sauce
10.	Tomato Juice	Bacon	French Toast Sandwiches			Vegetable Salad, French Dressing	Whole Apricots
11.	Orange	Sausage	Corned Beef Hash		Toast	Tomato Salad, French Dressing	Peach Shortcake
12.	Stewed Apricots	French Toast	Creamed Eggs and Mushrooms on Toast			Spring Vegetable Salad, Russian Dressing	Fruit Gelatin With Whipped Cream
13.	Grapefruit	Bacon	Cold Baked Ham	Hashed Brown Potatoes		Lettuce, Roquefort Cheese Dressing	Honey Ball Melon With Lemon
14.	Applesauce With Lemon	Scrambled Eggs	Tuna Fish Salad, Tomato Garnish		Hot Rolls		Lemon Tarts
15.	Baked Rhubarb	Sausage	Canadian Bacon	Corn Soufflé		Stuffed Prune Salad	Soft Ginger Cookies
16.	Tomato Juice	Bacon	Creamed Sweetbreads or Grilled Sardines on Toast			Adirondack Salad, Mayonnaise	Fruit Compote
17.	Orange	Soft Cooked Eggs	Southern Dinner		Muffins	Stuffed Celery Salad, Russian Dressing	Cantaloupe
18.	Figs	Canadian Bacon	Hamburger Patties on Buns	Grilled Tomatoes		Kidney Bean Salad	Fruit Compote
19.	Stewed Prunes	Scrambled Eggs	Tuna Fish Chow Mein			Health Salad, French Dressing	Peaches and Cookies
20.	Grapefruit	Bacon	Hot Roast Beef Sandwich			Jellied Carrot and Pineapple Salad	Butterscotch Brownies
21.	Honey Dew Melon	Poached Eggs	Cold Meats	Potato Chips		Tomato and Coleslaw Salad	Butter Brickle Ice Cream and White Cake
22.	Orange	Chipped Beef on Toast	Cheese Soufflé		Bishops Bread	Vegetable Relish	Spice Squares
23.	Grapefruit Juice	Fried Eggs	Canadian Bacon	Potato Salad		Green Olives	Fresh Pineapple and Bananas
24.	Cantaloupe	Sausage	French Toast Sandwiches			Fruit Salad, Whipped Cream Dressing	Frosted Chocolate Cookies
25.	Stewed Apricots	Broiled Ham	Vienna Sausage	Baked Tomato Stuffed With Spaghetti		Head Lettuce, French Dressing	Marble Cake
26.	Pineapple Juice	Soft Cooked Eggs	Salmon Pie With Biscuit	Fresh Asparagus, Butter Sauce		Ripe Olives	Baked Rhubarb
27.	Sliced Bananas	Bacon	Baked Spaghetti With Chipped Beef			Italian Salad, Russian Dressing	Orange Squares
28.	Fresh Apricots	Fried Eggs	Chicken Salad		Hot Rolls	Olives	Red Raspberries and Vanilla Cookies
29.	Applesauce	French Toast and Marmalade	Ham Rolls, Cheese Sauce	Fresh Asparagus		Tomato Salad, French Dressing	White Cake
30.	Cantaloupe	Poached Eggs	Baked Beans With Bacon Strips		Brown Bread	Egg Salad With Pickle Relish, Mayonnaise	Pineapple Cubes

Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago. Space precludes listing of cereals, breads and beverages. Several varieties of well known cereals are always offered for breakfast.

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NEWS IN REVIEW

Southeastern Group Covers Many Topics; to Invite Neighboring States Next Year

So successful was the first meeting of the Southeastern Hospital Conference held in Atlanta on April 8, 9 and 10, with the hospital associations of Georgia, Alabama and Florida participating, that invitations are to be extended to other Southern states to join the conference next year.

The officers of the conference suggested that Tennessee, Louisiana and Mississippi be invited next year and this was officially agreed to. Then hospital administrators from the Carolinas attending the conference asked that their states and Virginia also be invited. There was discussion of including Kentucky also.

A heated discussion of the value of the flat rate *versus* the special charge system of hospital billing featured the opening day of the convention. Those who have had experience with a carefully formulated flat rate plan were enthusiastic for it, claiming that it brings in as much income, reduces complaints from patients, and assists physicians to render better service. Critics of the flat rate plan stated that it was financially uncertain, and was not fair to the patients who do not utilize the special services.

A round table conference led by Fred Walker, superintendent, Duval County Hospital, Jacksonville, Fla., discussed general hospital problems. It was brought out in this conference that the nurse anesthetist in small hospitals often combined her duties with record keeping, assisting in the operating room, supervisory nursing and other work.

In discussing the question of linen service it was stated that a hospital laundry saved money for the hospital because the actual costs were decreased, less linen was lost and the linen was more carefully laundered.

Dr. Caldwell Banquet Speaker

Dr. Bert W. Caldwell, executive secretary, American Hospital Association, as the banquet speaker, declared that the hospital administration has ethical duties to the public, the professional staff, nurses, the press and employees. "The press is entitled," Doctor Caldwell declared, "to all the consideration and the news which you can give that is of value to the public and not harmful to the interests of the patient. Furthermore, reporters are entitled to kindness, courtesy,

truthfulness and the same confidence in their integrity that you expect them to have in yours."

In regard to employees, Doctor Caldwell declared that it is the administration's duty to see that they are kindly treated, that their wages are in line with those paid in industry, and that they receive good living environment. They have a right to expect understanding and sympathetic treatment of their problems, he declared.

Obtaining Endowments

Bryce L. Twitty, superintendent, Baylor University Hospital, Dallas, Tex., described several arrangements for obtaining hospital endowments. Under the John G. and May Hardin Foundation, for example, a sum of \$900,000 was given to the foundation by the Hardins who appointed themselves managers of the fund during their lifetimes. At their death this will be continued as a foundation for the benefit of five named charities, one of which is Baylor University Hospital. The advantage of such a plan, Mr. Twitty stated, is that the property is exempt from taxation and there is no likelihood of a contest by relatives. Other types of annuity plans were also presented by Mr. Twitty.

The American College of Hospital Administrators is not a labor union or an exclusive group of administrators from large institutions, declared John R. Mannix, assistant administrator, University Hospitals, Cleveland. It is an organization to promote and encourage better standards of hospital administration. Evidence of this is the work undertaken by the college, which he listed as (a) definition of a good hospital administrator, (b) development of a program for educating hospital administrators, (c) development of a placement service, (d) protection of qualified administrators against unjust attack, and (e) publication of an annual directory of all hospitals approved by the American College of Surgeons together with biographical notes regarding their administrators and the names of their trustees.

A new all-risk type of hospital liability insurance available only to hospitals approved by the American College of Surgeons was described by

Alden B. Mills, managing editor, *The Modern Hospital*. This policy, he stated, will provide better protection to the approved hospitals than they have been able to obtain heretofore and will do so at lower cost.

C. L. Sibley, superintendent, Birmingham Baptist Hospital, Birmingham, Ala., was chosen as president of the Southeastern Hospital Conference for next year. Robert Hudgens, assistant administrator, Emory University Hospital, Emory, Ga., was selected as secretary-treasurer. The president of each of the constituent state associations is automatically a vice-president of the Southeastern Hospital Conference.

New officers for two of the state associations are as follows: Georgia: Dr. L. C. Fischer, Crawford Long Hospital, Atlanta, president, and Charles W. Curry, Warren A. Candler Hospital, Savannah, secretary-treasurer; Florida: T. F. Alexander, Tampa Municipal Hospital, Tampa, president, and Gertrude Overstreet, Alachua County Hospital, Gainesville, president-elect. Alabama will elect its new officers later.

It was decided that the next meeting of the Southeastern Hospital Conference should be held in Birmingham in April, 1938.

A-Roving They Will Go

A late September cruise to Bermuda for tired convention "goers" is being arranged by the American College of Hospital Administrators following the organization's convention September 12 to 17 at Atlantic City, N. J. An all inclusive rate has been made for the eight-day tour, September 16 to 24, which will furnish transportation to and hotel accommodations while in New York, passage to Bermuda on the *Monarch of Bermuda* of the Furness line, and accommodations at the Castle Harbour Hotel on the islands. Nautically inclined delegates may learn full particulars about the trip from J. Dewey Lutes, executive secretary of the college and superintendent of Ravenswood Hospital, Chicago, who is in charge of the tours. Steamship reservations should be made not later than July 1.

To Serve Needy Patients

To supplement scientific care rendered to patients of the Part-Pay Medical and Dental Clinics, maintained at the Berkeley General Hospital, Berkeley, Calif., the Berkeley Hospital Guild has been organized. In addition to assisting needy patients, the other major objectives of the guild will be social service follow-up work, the maintenance of a volunteer library service, and cooperation with the women's field army of the American Society for the Control of Cancer.



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Western Hospital Association Meeting Draws 2,000 Delegates From 11 States

A record attendance of more than 2,000 members of the Association of Western Hospitals was recorded at the convention in Los Angeles April 12 to 15, meeting jointly with the Association of California Hospitals, the Catholic Hospital Association, and allied groups.

Eleven Western states, British Columbia, Hawaii, and Alaska were represented in the delegation.

In honor of the convention, "Hospital Week" was proclaimed in Los Angeles by Mayor Frank L. Shaw.

Nationally prominent speakers and subjects of timely interest in the hospital field included Dr. Benjamin W. Black, medical director, Alameda County Institutions, Oakland, Calif., who spoke on "The Manifold Obligations of Hospitals to the Public"; Executive Director Frank Van Dyk of the Association of Hospital Service of New York, and Dr. C. Rufus Roem, Committee on Hospital Service, American Hospital Association, both of whom spoke on "Group Hospitalization"; Dr. Basil C. MacLean, president, American College of Hospital Administrators, "The Growth, Causes and Cures of Malpractice Suits"; Howard Burrell, Los Angeles attorney, "Legislation and Hospitals"; Dr. Claude W. Munger, president, American Hospital Association, "Patients First," and Professor Ordway Tead, Columbia University, "Employee Welfare in the Broader Sense."

Supplementing Doctor MacLean's address regarding malpractice suits, a feature in drama form, "The Case of

Blank vs. Memorial Hospital," was presented, with a jury drawn from the delegates. The cleverly presented drama brought home the points of interest with vivid reality.

By skilled arrangements of the convention committee, headed by Superintendent R. E. Heerman, California Hospital, Los Angeles, the various allied sections participated in the general meetings and also held their own sectional meetings without conflict. Noteworthy was the cancer clinic meeting.

A highlight of the recreational activities of the convention was a visit to a United States Navy floating hospital, U.S.S. *Relief*, at anchor in Los Angeles harbor.

Dr. Glenn E. Myers, superintendent, Compton Sanitarium, Compton, Calif., who took office for the coming year as president of the association, arranged for convention radio time on Los Angeles stations. A. C. Jensen, superintendent, Fairmont Hospital, San Leandro, Calif., was chosen president-elect.

W. C. Crandall, Scripps Memorial Hospital, La Jolla, Calif., was elected president of the Association of California Hospitals, to succeed George N. Wood, of Peralta Hospital, Oakland, Calif.

Preceding the convention, advance delegates attended the unveiling of the statue of Florence Nightingale, by David Edstrom, on April 11 at Lincoln Park. This statue was financed by the hospitals of Southern California and the federal arts project.

Fever Theraputists Hold First Congress in New York

The first international congress on fever therapy was held in New York City, March 29 to 31, with about 200 of the world's leading authorities participating.

At a dinner attended by approximately 350 distinguished physicians and scientists, Charles de Fontnouvelle, Consul General of France, decorated two American physicians and two American scientists with the French Legion of Honor in recognition of their contributions to the development of fever apparatus and their application in the relief of human suffering.

The recipients were Dr. William Bierman of New York City, president of the American Congress of Physical Therapy and director of the Department of Physical Therapy at Mount Sinai Hospital; Dr. Walter Simpson,

director of research at the Kettering Institute of Medical Research, Miami Valley Hospital, Dayton, Ohio; Charles F. Kettering, inventor, vice-president of the General Motors Corporation, who invented the Kettering fever box, endowed a research institute and distributed his apparatus free to several institutions, and Dr. Willis R. Whitney, former director of the research laboratories of the General Electric Company, who invented short-wave radio apparatus for the production of artificial fever.

Flames Terrorize Patients

Fire recently demolished the interior of the two-story brick structure of the women's infirmary of the Toledo State Hospital, Toledo, Ohio, driving out 119 women patients. Nurses had a terrific struggle with panic-stricken women. The fire originated in the basement of the building.

Chicago Institutions Report Increased Incomes in 1936

The sixteen hospitals and fourteen clinics in Chicago reporting to the Community Fund received 14 per cent more income from patients in 1936 than in 1935, or an increase of \$600,000. This increase enabled the institutions to reduce their combined deficit to \$74,290, which is one-third of the deficit reported in 1935.

The hospitals, which have a combined capacity of 4,300 beds, gave nearly two-fifths of their services and the clinics nearly four-fifths of their services free during the year. For 1937, \$331,709 has been allotted by the Community Fund for free hospital and clinic service, and this is \$200,000 more than the 1936 allotment when 240,000 patients were cared for by these institutions.

This report was made by Dr. Ludwig Hektoen, chairman of the health division of the Council of Social Agencies of Chicago.

Bequeaths Fortune to Research

Expressing a wish that mankind's infirmities not only be corrected, but prevented, by his fortune, Francis Fleury Prentiss, who died April 1, and who gave Cleveland its St. Luke's Hospital, left 70 per cent of his estate, estimated at \$3,000,000 to St. Luke's, to erect and maintain a separate laboratory building for advanced medical research. Not only did Mr. Prentiss in his will recommend a research department for the hospital, but he also asked the trustees to provide for the reduction of rates of paying patients and the increase of free service to indigent patients. Further, he suggested a nurses' home. These expansions would be undertaken when the accumulation of income in the fund exceeds the amount which the hospital trustees desire to use for operating purposes. Mr. Prentiss was the founder of the Cleveland Twist Drill Company.

\$400,000 Expansion Sought

New Rochelle Hospital, New Rochelle, N. Y., has projected a \$400,000 enlargement of its present plant. The new building will be five stories high, will accommodate sixty additional patients, a complete new surgical department, and by releasing space now used for surgery in the existing building will make room for an improved and enlarged obstetrical department. Earl C. Sams, chairman of the hospital's board of governors, heads a new building fund committee, which is seeking contributions to finance the expansion program. Mr. Sams, incidentally, made the first subscription to the fund in the amount of \$51,000.

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Legislative Matters Occupy Ohioans at Spring Meeting; Dr. Carter Is President-Elect

As usual the meeting of the Ohio Hospital Association in Columbus on April 13 to 15 was concerned as much with the development of closer co-operation between the hospitals and the various departments of state government as it was with the purely intramural activities of the hospitals.

Among the legislative matters dealt with, as reported by B. W. Stewart, chairman of the state relations committee, were:

1. A tentative agreement to pay hospitals for the care of crippled children at their per capita costs to a maximum of \$6 for the first twenty-one days of hospital care and a maximum of \$3 thereafter. The state is committed to this principle but wants to proceed slowly.

2. Negotiations with the industrial commission looking toward acceptance of the principle that infant days should be counted as equal to one-fourth the cost of adult days.

3. Interpretation of the minimum wage law to hospitals.

4. A special county tax for welfare purposes, which is still pending in the legislature.

5. Amendment of the general code to permit group hospitalization to go outside of county boundaries, still pending.

6. A bill to provide state pay for the care of the aged sick up to sixty days at the established pay rate in hospitals. This has passed the state senate and is pending in the house.

7. A bill to license hospitals. This bill was sponsored by the state health commission and the building commission but will not be acted upon this session.

Auto Accident Question

Considerable difficulty has been experienced by the state hospital association over the settlement of claims for the care of auto accident cases because a few hospitals have established rates that are much below their per capita costs. The bureau of motor vehicles objects to paying a rate that is higher than the patient himself would have had to pay.

Officials of the association strongly urged that all hospitals bring their charges up to the amount of their per capita costs and then grant reductions to patients who cannot afford to pay the established rate. "It is unfair to your contributors and the community chest," declared Mr. Stewart, "to charge less than cost to those who can afford to pay full cost because then there is less money to use for those who really need aid."

Syphilis prevailed among 16.6 per cent of the patients treated under

workmen's compensation in Ohio last year, declared Dr. Sidney McCurdy, medical supervisor, Industrial Commission of Ohio. "This influences diagnosis, prognosis and care," he said. "I want routine Wassermanns as a part of hospital care of our patients. Without them, it is impossible to allocate the cost fairly."

Doctor McCurdy admitted that it takes almost six weeks for an authorization for a hernia operation to be approved by the industrial commission. "We have to investigate in the field. We'll pay if it's our case and most of them are. Can't the hospitals help us solve this question by going ahead with the operation and taking a chance with us?"

Is Exemption a Mistake?

The exemption of hospitals under the Social Security Act was roundly scored by Harry H. Graef, superintendent, Children's Hospital, Akron, Ohio. "I contend that the exemption is wrong because it disregards the right of hospital employees to benefit under the act and they are usually not paid enough to enable them to provide for their old age privately. Furthermore, I object to the uneconomic and unprofessional practices of certain hospitals who make themselves into professional mendicants."

In the discussion following Mr. Graef's paper it was revealed that nearly all the administrators present wanted to provide old age benefits for their employees but only two were concerned with unemployment insurance.

Nursing problems aroused a spirited controversy, Mrs. Elizabeth P. August, secretary of the Ohio Nurses Association, declaring that hospitals were finding a shortage of nurses because they discriminated against the older nurses. "A woman of thirty is not wanted as a general duty nurse. As a science instructor or supervisor, the woman from thirty-five to forty is not wanted; and after she has reached forty-five there is no place for the nurse in hospital or public health work," declared Mrs. August. She also stated that low pay was a prime cause of an apparent shortage.

Hospital administrators disagreed with Mrs. August stating that there was a real shortage of nurses in Ohio and that older nurses were excluded only when they were deficient in education or personality.

Recent developments in hospital service plans were discussed by John A. McNamara, director, Cleveland Hospital Service Association. This plan is reported to have 51,000 subscribers now.

Olive Jane Brown, superintendent,

Detwiler Memorial Hospital, Wauseon, was inducted as president of the association succeeding Guy J. Clark. The new president-elect is Dr. Fred G. Carter, Christ Hospital, Cincinnati.

Meeting with the association were the dietitians, record librarians, nurse anesthetists, hospital obstetricians, laboratory technicians, and physiotherapists.

Strikes, Union Activities

Reported From Various Points

The hospital union situation in New York entered a new phase on April 21 when sixteen of the sit-down strikers from Jewish Hospital, Brooklyn, as well as the president of the Hospital Employees Union were convicted of violating an old section of the penal code. The maximum sentence that can be levied is twelve years imprisonment. Actual sentencing was deferred until April 30.

Section 1910 of the penal code of New York State makes it a misdemeanor for a person willfully to "break a contract of service for hire, knowing, or having reasonable cause to believe, that the probable consequence of his so doing will be to endanger human life or to cause grievous bodily injury or to expose valuable property to destruction or serious injury." This statute was passed, it is reported, in 1880 and has seldom or never been invoked before.

The first evidence of union activities in Chicago voluntary hospitals occurred last month when maintenance employees of Augustana Hospital presented demands for higher pay, shorter hours and union recognition. It was reported that between 80 and 90 per cent of the maintenance employees were members of a hospital employees union chartered by the American Federation of Labor. The hospital granted a 10 per cent pay increase effective April 1 and agreed to give one full day off in seven and to go on to a working week of approximately forty-eight hours. It did not agree, however, to recognize the union. Instead it requested that the Chicago Hospital Council consider the question and recommend what action should be taken.

In Seattle negotiations between the hospital council and the labor council were postponed because hospital officials were deeply engrossed in the regional meeting of the American College of Surgeons.

The press reported that a strike of sixteen orderlies at the Allegheny General Hospital, Pittsburgh, was called to obtain increased pay and "improved working conditions." The orderlies were replaced and strikers picketed the hospital.

A union was formed of hospital employees in the University Hospital, Ann Arbor, Mich., but had not yet presented its demands.



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NEW BUILDING PROJECTS

NEWMAN, CALIF.—Work will start soon on the new West Side Hospital. The building will be of stucco, air conditioned and earthquakeproof and fireproof. There will be ten rooms for patients and living quarters for Dr. A. M. Roscoe, the superintendent. The cost, including furnishings and equipment, will be over \$35,000.

NEW HAVEN, CONN.—Plans are still under way for building the \$4,000,000 State Training School for Mental Defectives at South Britain. A site of about 1,492 acres has been purchased, a superintendent secured, and plans for the buildings drawn up. The institution will constitute a community in itself, including a school, cottages, greenhouses and a farm. The cottages will house from fourteen to sixty persons, each cottage having a house mother, a house father or both, and approximating as nearly as possible the living conditions of a normal home.

MARSHALLTON, DEL.—The new \$104,000 addition to the Brandywine Sanatorium, recently opened, provides for fifty new beds, bringing the total bed capacity up to 160. Including equipment, the value of the new addition is set at \$120,000.

CHICAGO, ILL.—The dedication of the new \$200,000 annex of St. Francis Hospital will take place in May. Work was started last July. The present building of the hospital was erected in 1923.

GENESEO, ILL.—The J. C. Hammond City Hospital will be enlarged at a cost of \$33,250. Geneseo city council has voted to provide \$8,000 for the project, the hospital will meet about \$10,000 of the cost and a PWA grant of \$14,962 will be secured. The proposed addition is a two-story wing, which will include seven rooms and a new elevator.

CHELSEA, MASS.—The United States Marine Hospital is soon to be replaced by a new hospital to be erected at Brighton on a site overlooking the Charles River basin and Boston Harbor.

DETROIT, MICH.—The government has accepted the site near Detroit offered by Henry Ford for a veterans' hospital. Funds for the institution already have been appropriated and the veterans' administration will take over the property at once.

ST. PAUL, MINN.—New construction and alterations of the first and second floors of the northwestern wing of the Charles T. Miller Hospital are expected to be completed by June 1, making it possible to install a 1,200,000-volt constant potential x-ray therapy machine. Four patients can be

treated at a time with the new machine, which will be used primarily for the treatment of deep-seated tumors. Dr. Edward Schons and Dr. John P. Medelman will be directors of the radiologic department of the hospital.

ST. LOUIS, MO.—The \$3,160,000 Homer G. Phillips Hospital for Negroes was dedicated and opened recently. The institution occupies all but one corner of two city blocks and consists of an administrative building with two ward wings to care for 600 patients, a service building and a nurses' and superintendent's home. Dr. Orval S. McClellan is superintendent.

RENO, NEV.—A new wing is under construction at the Washoe General Hospital, to be occupied by the maternity service, including delivery room, nursery and private rooms.

ALBANY, N. Y.—A new laboratory for the departments of physiology, pharmacology and experimental surgery at Albany Medical College was recently dedicated to the memory of the late Dr. Theobald Smith, regarded as the outstanding alumnus of the school. The new laboratory was remodeled from the old Albany County Hospital.

BROOKLYN, N. Y.—A six-story hospital building is to be erected by Jewish Sanitarium for Incurables. The project will cost \$200,000. The architect is J. E. Goldstein.

COHOES, N. Y.—The new one-story operating unit at Cohoes Hospital has been completed at a cost of more than \$25,000. The unit measures 40 by 30 feet, and on the western wall a glass brick window occupies 13 by 9 feet of space. More than a hundred of these bricks, which will admit light but keep out bright sun, were used in the window. The unit is air conditioned, and lighted with a shadowproof ceiling light which can be regulated to three degrees of light. Emergency lighting power has been provided. The hospital's old operating room has been converted into a contagious division.

NEW YORK CITY.—The new central nurses' home for Welfare Island hospitals is nearing completion. It will house 600 nurses and is being built at a cost of \$1,610,000. The power plant for the new units is being constructed at a cost of \$597,000.

Columbia University's College of Physicians and Surgeons, New York City, will add eight floors to their building to provide greater laboratory facilities for graduate medical education. The expansion is made possible by gifts amounting to \$500,000, half of which was a grant from the Com-

monwealth Fund. There will be laboratories for anatomy, pathology, biologic chemistry, physiology and bacteriology. . . . A syphilis clinic was recently opened by the New York Hospital in the Lenox Hill-Kipps Bay district. The clinic will serve two purposes: a demonstration unit for handling the disease in a densely settled metropolitan area, and a teaching unit for the training of medical students in treatment and methods of study. Patients seeking admission from the district will be charged regular out-patient rates if able to pay, but no patient will be refused admission.

OLEAN, N. Y.—Ground will be broken shortly for a new Catholic hospital to be erected by the Sisters of the Order of St. Francis, to be known as the St. Francis Hospital. It is hoped to have the hospital completed by fall.

WEST HAVERSTRAW, N. Y.—Remodeling is being done at a cost of over \$130,000 to transform the old hospital building of the New York State Reconstruction Home into a modern unit with bed space for thirty children, more elaborate dental and x-ray facilities, examination rooms, medical and social service offices and bed space for indisposed employees. A new modern operating room will obviate the necessity of taking some of the surgical cases to New York City.

AMHERST, N. S.—Highland View Hospital will have a new tuberculosis annex next spring. The sum of \$16,000 has been authorized for the purpose by the Minister of Health.

STRATFORD, ONT.—One wing of the Stratford General Hospital was recently remodeled, providing space for a modern x-ray department and an up-to-date emergency room.

CROCKETT, TEX.—A new unit has been added to the Butler Hospital by Dr. C. W. Butler, Jr. The unit has two stories and consists of seven apartments and a ward. Other improvements include a wide concrete driveway from the street to the ambulance landing, and a number of garages to serve the hospital staff and occupants of the apartments. The cost of the improvements is estimated at around \$25,000.

GALVESTON, TEX.—A new building for the Hospital for Crippled and Deformed Children is being built at a cost of \$220,000, of which \$110,000 was appropriated by the state legislature and \$20,000 by the Sealy and Smith Foundation of the John Sealy Hospital, which also furnished the site. The new building has four floors and will accommodate eighty patients. The equipment is such that any type of corrective work for crippled children can be undertaken. Occupational therapy and formal education are provided for these children, many of whom have never gone to school.

WHEN HEROES RETURN

More than cheers greeted heroes when they came home from war. Medals, pensions, bonuses and other material evidence of gratitude were forthcoming from a relieved and thankful nation.

Hospitals now return from the siege of the depression—some scarred, many with depleted resources, all of them heroes in battles against what many thought insuperable odds.

Will the public acclaim these heroes who bear the names of hospitals? Will the public restore their resources and place them in a role of even greater usefulness, in this more normal phase of the life of the country?

The answer is yes.

Fresh, convincing examples from various states show an unmistakable cause-and-effect sequence: The devotion, courage and diligence of your community hospital during the trying, lean years that are now passing have earned a public goodwill which can be translated into the funds required for replacement, enlargement and modernization—provided a deliberate, ethical and scientific procedure is employed.

Consultation with your Board or Committee can be arranged without obligation.



FIFTH AVENUE GREETS THE A. E. F. (Underwood & Underwood)

• **NEW CONSTRUCTION:** During the first three months of 1937 alone eight projects representing a total of \$3,025,000 of new hospital construction were entrusted to the financial direction of Will, Folsom and Smith, Inc.

• **GREEN LIGHTS:** In an Eastern city of 35,000, the first 40 gifts in a current hospital campaign total more than \$360,000. The public campaign to be conducted in October will seek the balance of a \$450,000 program.

WILL, FOLSOM AND SMITH, INC.

*Specialists in Hospital
Finance and Public
Relations Since 1919*

TWENTY-FIVE WEST FORTY-THIRD STREET
NEW YORK

*There Is No
Comparable Record
in the Hospital Field*

New Jersey Trustees Meet to Discuss Problems

"To what extent should the tax dollar support the voluntary hospital?" was a question raised by Dr. Andrew F. McBride, former commissioner of labor of New Jersey and trustee of St. Joseph's Hospital, Paterson, before the spring conference of the New Jersey Hospital Association. Dr. McBride referred to the 3 cents-a-day plan and stressed the need for giving it greater publicity. He also laid emphasis on the desirability of greater contributions to voluntary hospitals from industry, and urged the formation of a standing committee of the association to meet with various agencies and promote better legislation.

On the same occasion, which was a special program for hospital trustees, William Orchard, trustee of Orange Memorial Hospital, Orange, expressed the opinion that it is the business of hospital trustees and hospital staffs to see that the community understands the hospital.

Curtis R. Burnett, president, Presbyterian Hospital of Newark, who was to have discussed Doctor McBride's paper, was unable to be present, so his comments were read by J. D. Colman, executive secretary, Hospital Council of Essex County. Sherrard Ewing, executive director, Paterson Community Chest, discussed Mr. Orchard's paper. Helen Young, R.N., director of nurses, Presbyterian Medical Center, New York City, gave some suggestions on financing a qualitative nursing service, following which John R. Howard, Jr., superintendent, Muhlenberg Hospital, Plainfield, reviewed in detail some of the points presented by Miss Young. Edgar C. Hayhow, president of the association, presided.

Minnesota Group Chooses May

Varied problems of hospital administration will come before the Minnesota Hospital Association at its meeting, May 13, 14, and 15 at Rochester. Sessions have been arranged in which record keeping, nursing, occupational therapy, dietetics, medical social work, social security, physiotherapy and anesthetics will be discussed. Included among the speakers will be Dr. C. H. Mayo of the Mayo Clinic; Robert Neff, president-elect, American Hospital Association; Dr. Bert Caldwell, American Hospital Association; Dr. B. F. McLean, president, American College of Hospital Administrators, and Dr. M. T. MacEachern, American College of Surgeons. The president of the Minnesota association is Dr. A. F. Branton. The Minnesota Record Librarians Association will meet May 14 in joint session with the hospital association. A varied program will be presented.

Coming Meetings

Tri-State Hospital Association (Indiana, Illinois, Wisconsin).
Next meeting, Chicago, May 5-7.

National League of Nursing Education.
Next meeting, Boston, May 9-14.

Mississippi Hospital Association.
Next meeting, Meridian, May 10.

Minnesota Hospital Association.
Next meeting, Rochester, May 13-15.

Arkansas Hospital Association.
Next meeting, Little Rock, May 19.

National Executive Housekeepers' Association.
Next meeting, Cleveland, May 20-22.

Hospital Association of New York State.
Next meeting, New York City, May 20-22.

American Association of Medical Social Workers in conjunction with National Conference of Social Work.
Next meeting, Indianapolis, May 23-29.

New Jersey Hospital Association.
Next meeting, Atlantic City, May 27-29.

National Tuberculosis Association.
Next meeting, Milwaukee, May 31-June 3.

Hospital Association of Rhode Island.
Next meeting, Wakefield, June.

Hospital Association of Pennsylvania.
Next meeting, Buck Hill Falls, June 2-4.

Advisory Board for Medical Specialties.
Next meeting, Atlantic City, June 6.

American Medical Association.
Next meeting, Atlantic City, June 7-11.

Mid-West Hospital Association.
Next meeting, Colorado Springs, Colo., June 10-11.

Catholic Hospital Association.
Next meeting, Chicago, June 14-17.

Manitoba Hospital Association.
Next meeting, Brandon, June 24-25.

Hospital Association of Nova Scotia and Prince Edward Island.
Next meeting, Sydney, N. S., July 6-7.

International Hospital Association.
Next meeting, Paris, July 6-11.

National Hospital Association.
Next meeting, St. Louis, Aug. 15-17.

Canadian Hospital Council.
Next meeting, Ottawa, Sept. 8-9.

National Association of Nurse Anesthetists.
Next meeting, Atlantic City, N. J., Sept. 14-16.

American College of Hospital Administrators.
Next meeting, Atlantic City, Sept. 12-17.

American Hospital Association.
Next meeting, Atlantic City, Sept. 13-18.

American Protestant Hospital Association.
Next meeting, Atlantic City, Sept. 10-12.

Children's Hospital Association.
Next meeting, Atlantic City, Sept. 13-17.

American Public Health Association and National Organization for Public Health Nursing.
Next meeting, New York City, Oct. 5-8.

Saskatchewan Hospital Association.
Next meeting, Regina, Oct. 10.

American Dietetic Association.
Next meeting, Richmond, Va., Oct. 18-22.

Ontario Hospital Association.
Next meeting, Toronto, Oct. 20-22.

American College of Surgeons.
Next meeting, Chicago, Oct. 25-29.

Association of Record Librarians of North America.
Next meeting, Chicago, Oct. 25-29.

Kansas Hospital Association.
Next meeting, Newton, Oct. 30.

State Promotes Syphilis Control

To further the syphilis control program in South Carolina, plans were adopted at a meeting of representatives of the state board of health and the state medical association, for financing the project with social security funds. It was agreed that the state should furnish certain specified drugs for treatment to both indigents and paying patients. A statewide survey to determine the incidence of syphilis is to be made through various institutions, groups, and private physicians. Dr. Sedgwick Simons, Columbia, S. C., of the staff of the state board of health, has been placed in charge of the syphilis control program.

Campaign to Be Launched

St. Peter's General Hospital, New Brunswick, N. J., will launch a public campaign for \$250,000 early in June. The funds are being sought to finance a new school of nursing education and nurses' home, to meet requirements of the state board of examiners of nurses. The new building, also, by evacuating nurses and Sisters from rooms they now occupy in the hospital, will increase the institution's capacity for patients by at least thirty beds.

Complete 1,000,000-Volt X-Ray Tube at Columbia

The million-volt x-ray tube, which has been under construction at Columbia-Presbyterian Medical Center, New York City, for the last two years, was recently completed, and dedication services were held on January 14 by Dr. Francis Carter Wood, director of the Crocker Institute for Cancer Research, Columbia University, New York City.

In the specially constructed building which houses the tube, second of its kind in the world, East coast cancer men gathered to inspect the instrument. "Whether this high voltage machine will prove to be of such advantage in cancer therapy that it will justify its cost," said Doctor Wood, "as well as its running expenses, is not certain, and the facts can be determined only by a careful study of patients."

The cost of the tube is about \$25,000, five times that of the commercial 200,000-volt machine, but five patients may be treated at once. It was constructed under the direction of Frank M. Exner, physicist of the Institute of Cancer Research, from plans developed by David H. Sloan of the University of California, where the first tube of this kind was built.

Before The Rise of Polyclinics

Hospitals Depended on Webb's Alcohol



T. F. Healy Collection

POLYCLINICS—A CASE OF SPINAL CURVATURE

Medical knowledge stepped out of dreary text-books and became a vital, new science when it met practitioners in the early polyclinic hospitals. Here students and doctors mingled under laboratory conditions most favorable to the transfer of ideas. Here, too, students acquired the same faith that more experienced medical men placed in Webb's alcohol.

THROUGHOUT the evolution of the hospital nearly every change, every forward step has served to make alcohol of greater importance to medicine. In the nineties, when the polyclinic hospital began to assume its rightful position in the medical field, the spotlight was focused on the hospital pharmacy.

From its shelves the many clinics requisitioned scores of vital preparations that could not be made with anything but alcohol. And when the call for alcohol went out, it usually was for Webb's.

By 1890 the House of Webb had already completed over a half a century of distinguished service to hospitals. That service was at once both the simplest and most difficult of tasks—that of supplying pure alcohol in any crisis.

When Webb became a part of the U. S. Industrial Alcohol Co. in 1915,

hospitals were assured of an unlimited supply of two recognized brands of pure alcohol, Webb's and U.S.I.-U.S.P.

This evolution of the hospital is not yet complete. New and more sweeping changes will come. There is one way to safeguard your alcohol requirements for today and tomorrow: specify Webb's and U.S.I.-U.S.P. brands.



ALCOHOL

U.S.I.-U.S.P. WEBB'S

ONE HUNDRED YEARS OF SERVICE TO HOSPITALS

U. S. INDUSTRIAL ALCOHOL CO. 60 EAST 42ND STREET, NEW YORK
BRANCHES IN ALL PRINCIPAL CITIES

Questions of Salaries and Hours of Work

Uppermost as Michigan Group Meets

The salaries and perquisites of hospital employees in Michigan received careful attention at the meeting of the Michigan Hospital Association held in Ann Arbor, April 15 and 16. In preparation for the meeting, R. G. Greve, secretary of the association, prepared a tabulation of the hours, salaries, maintenance, free hospitalization and vacations of employees in thirty-seven Michigan hospitals. This furnished the basis of extensive discussion.

Mr. Greve's tabulation showed a wide variation among the hospitals, even those in the same communities. Hours for general duty nurses, for example, in Wayne county (Detroit) ranged from 40 to 54; in the hospitals in and east of Lansing they varied from 40 to 56 hours, and in the hospitals west of Lansing from 48 to 64 hours. Similarly salaries (including the value of maintenance) varied in the three areas as follows: Wayne county, \$100 minimum to \$135 minimum; Lansing and east, \$85 to \$113; west of Lansing, \$82 to \$125. In these figures meals are valued at \$25 per month, room at \$12, and laundry at \$8.

Similar data for ward supervisors, orderlies, ward maids, porters or janitors, kitchen maids and elevator operators were presented by Mr. Greve.

The president was authorized to appoint a committee to recommend standards regarding free hospital care for employees, sick leave, vacations and maintenance.

Experiences With Unions Told

The question of hospital labor unions brought forth accounts of experiences on this score at Harper Hospital, Detroit; University Hospital, Ann Arbor, and Eloise Hospital, Eloise. In the third instance, it was reported that the formation of a union had helped the superintendent obtain his requests for more funds in order to increase salaries and reduce hours. Dr. Stewart Hamilton, superintendent, Harper Hospital, Detroit, reported that a brief sit-down strike of his laundry employees was settled over a weekend by a pay increase. "We told our employees they could join the union if they wished to," Doctor Hamilton reported.

The use of ward clerks at University Hospital, Ann Arbor, was presented by Miss Walmsley of the nursing staff. These clerks have proved helpful to the nurses on the ward by relieving them of the necessity of answering telephones, charting temperatures, pulse and respiration, handling clerical work in admitting, transferring and discharge of patients, caring for time slips and many other

routine clerical duties. The clerks have an eight-hour day and a five and one-half-day week and receive \$70.50 per month without maintenance.

An unusual feature of the program was a presentation of a jury panel by the senior nurses of the University Hospital entitled "As Others See Us." The student nurses summarized the various criticisms of hospital service expressed by patients in magazine articles and personal contacts and suggested methods of overcoming them. The audience, too, was invited to participate in the discussion which centered upon such matters as discourtesy, incompetence, noise, lack of privacy, bothersome routine, and emphasis on science at expense of human relationships. The need for a hospital hostess was emphasized both by the students and the audience. It was also suggested that all employees who have any contact with the public should attend a course in human relations.

Mary Skeoch, superintendent, St. Luke's Hospital, Marquette, was elected president for the coming year, succeeding Dr. Donald M. Morrill, superintendent, Receiving Hospital, Detroit. Robert G. Greve, assistant director, University Hospital, Ann Arbor, was reelected secretary.

Allied Professions to Meet With Medical Group

A unique feature of the meeting of the Minnesota State Medical Association, May 3, 4, and 5, to be held at St. Paul, will be the congress of allied professions.

The congress, scheduled for May 3, is planned as a common meeting ground for all professions allied in the care of the sick—doctors, dentists, nurses, hospital workers, pharmacists and social workers.

Speakers at the meeting will include Helen Beckley, director of social service at Cook County Hospital, Chicago; Dr. C. Rufus Rorem, chairman of the committee on hospital service, American Hospital Association; Daisy Dean Urch, president of the Minnesota State League of Nursing Education; Dr. E. H. Bruening, chairman of the economics committee of the American Dental Association; Dr. Charles H. Rogers, D. Sc., dean of the College of Pharmacy, University of Minnesota; Rev. Alphonse M. Schwitalla, S. J., president of the Catholic Hospital Association; Dr. Martha Eliot, assistant chairman of the Children's Bureau, U. S. Department of Labor; Dr. Morris Fishbein, Chicago, editor of the *Journal of the American Medical Association*.

BEQUESTS AND GIFTS

BOSTON, MASS.—The Massachusetts General and the New England Deaconess Hospitals are each to receive \$100,000 from the estate of the late William A. Sargent of Brookline, Mass., in memory of his mother. . . . The will of the late Mary Lee Ware, Boston woman, designates that the Boston Lying-in Hospital will receive \$40,000; the Massachusetts Society for Mental Hygiene, \$20,000, and the Massachusetts Eye and Ear Infirmary, \$20,000 from her estate.

CHARLESTOWN, MASS.—The estate of the late Frank W. Lowe is left in trust as the Frank W. Lowe Trust for Free Beds in Hospitals. His will directs that semi-annually one-eighth of the income of the trust is to be paid to a nephew, and one-eighth to a niece, for life. The remainder of the fund is to be allowed to accumulate, and each time it reaches \$25,000 it is to be used to purchase a free bed in some small community.

NEW YORK CITY.—The New York Hospital will eventually receive \$127,736 from the estate of the late Katherine Grace Snyder. The hospital will receive immediately the sum of \$47,736 from the residuary estate. A trust fund of \$75,000 is set up for a sister of Mrs. Snyder's, to pass entirely to the hospital on her death. The hospital is to receive five-sixtieths of a second trust fund amounting to \$60, upon the death of a niece. . . . Beth Israel Hospital is to receive \$5,000 from the estate of the late David Epstein.

BRADFORD, PA.—Thomas Kennedy, oil producer and banker, recently presented his town's hospital with \$100,000 to be used in the construction of a new surgical suite, to be the first unit in a group of new buildings for Bradford Hospital. According to Mr. Kennedy, the addition will be a three-story, fireproof building to house a surgical unit, an x-ray department, physiotherapy department, and an obstetric suite. No patients will be housed in the unit.

PITTSBURGH.—Presbyterian Hospital will receive \$25,000 from the estate of the late Edward Pitcairn. . . . The income from \$1,000,000 is to be distributed among sundry hospitals in this city and Philadelphia, according to the will of the late Mrs. George Fales Baker.

MARLIN, TEX.—The Buie-Allen Hospital was the proud recipient of a deep therapy, x-ray unit which has an output of 200,000 kilovolts at eight milliamperes, the gift of J. C. McClelland, who dedicated it to those afflicted with malignant internal diseases and other ailments which medical science has found respond to x-ray therapy.



WHAT HAVE THESE "LITTLE THINGS" IN COMMON?

A HYPODERMIC needle... a cake of soap. Both are "Little Things," physically speaking. But could you get along without them?

You know how essential it is to supply your staff with hypodermic needles of the finest and highest quality... for safety's sake.

"But what about soap?" you may ask. Well, isn't it just as true that the soap used in bathing your patients, for safety's sake, should be of finest quality? "Of course!"

Your patients, too, appreciate your using the soap they prefer. And in most cases that means PALMOLIVE. For Palmolive is the largest selling toilet soap in the world. In fact, the

very people you serve choose it for use in their own homes.

Why is Palmolive the favorite?

Palmolive is made with a blend of *Olive and Palm oils*. No artificial coloring matter. No adulterants or animal fats. It's bland. Non-irritating. Soothing to sensitive, fever-dried skins. It lathers freely in warm or cold

water. It's *all* pure... gentle... soap.

Palmolive's Extra Quality is FREE!

Yes, actually FREE! Because Palmolive Soap costs no more than many less-favored brands.

Your C.P.P. Representative will gladly quote prices on Palmolive Soap—and on the finest, most economical soaps for laundry and maintenance use, too. Or, write Colgate-Palmolive-Peet Co., Industrial Dept., 105 Hudson St., Jersey City, N. J. for valuable Free Booklet: "Hospital Housekeeping and Cleanliness." It's a dependable soap-buying guide. No obligation. Send for your copy—TODAY!



Palmolive Soap

CHOSEN EXCLUSIVELY FOR THE DIONNE QUINS BY DR. DAFOE

NAMES IN THE NEWS...

DR. STEPHEN MANHEIMER, assistant director of Mount Sinai Hospital, New York City, who has been associated with that institution for ten years, has been appointed director of the Jewish Hospital, Brooklyn, N. Y. He succeeds DR. MORRIS HINENBURG, who has resigned to accept a combined administrative and clinical position as superintendent and medical director of the Denver Sanatorium of the Jewish Consumptives' Relief Society, Denver, on June 1.

CARL P. WRIGHT, JR., has been appointed superintendent of the United Hospital, Port Chester, N. Y. Mr. Wright has been assistant superintendent at New Haven Hospital, New Haven, Conn., and before that was associated with Grasslands Hospital, Valhalla, N. Y. Previously he was with Dr. S. S. Goldwater in the department of hospitals, New York City. He is the son of Carl P. Wright, administrator of the General Hospital, Syracuse, N. Y., and executive secretary of the Hospital Association of New York State.

BERTHA M. HALL has resigned as superintendent of the General and Marine Hospital, Owen Sound, Ont. Her successor is PEARL L. MORRISON, formerly of Sibley Memorial Hospital, Washington, D. C.

DR. BERTHOLD S. POLLAK will be medical director of a new tuberculosis hospital, a unit of Jersey City Medical Center now nearing completion in Jersey City, N. J. Recently Doctor Pollak was honored by a reception on his completion of thirty years as medical director of the Hudson County Tuberculosis Hospital, Secaucus, N. J.

DOROTHY DE HART has been made executive assistant of Roosevelt Hospital, New York City, in charge of all food departments.

DR. BARTON W. DORBANDT, assistant superintendent of the San Antonio State Hospital, San Antonio, Tex., has been appointed superintendent of the Wichita Falls State Hospital. He will succeed DR. CHARLES W. CASTNER, who was appointed chief of the new division of eleemosynary institutions in the Texas state government.

JUNE MOE has been appointed superintendent of Oneida City Hospital, Oneida, N. Y. Miss Moe has been second assistant superintendent at Genesee Hospital, Rochester, N. Y.

DR. JAMES C. WALSH, director of Schenectady County Tuberculosis Hospital, Schenectady, N. Y., resigned from that post on April 15 to become superintendent of Nassau County Sanatorium, Farmingdale, N. Y. Doctor

Walsh will succeed DR. ALQUIN J. DAVIS, who died last summer.

DR. FRANK G. BOUDREAU, chief of the service of epidemiologic intelligence and public health statistics of the League of Nations, has been appointed executive director of the Milbank Memorial Fund of New York, to succeed the late EDGAR SYDENSTRICKER. This appointment took effect April 1.

GRACE P. HASKELL, R. N., superintendent of the Wentworth Hospital, Dover, N. H., has resigned following thirty-one years of service. Miss Haskell retires to take a much needed rest from professional duties.

DR. WILLIAM L. RUSSELL, general psychiatric director of New York Hospital, New York City, since 1926, retired recently and was appointed consulting psychiatrist of the hospital and medical director emeritus of the Westchester Division (formerly Bloomingdale Hospital) at White Plains, N. Y. Doctor Russell went to Bloomingdale Hospital in 1911 and was medical director there until his appointment as general psychiatric director in 1926. He is professor of psychiatry emeritus at Cornell University Medical College.

DR. JAMES E. HOLMES, director emeritus of the Methodist Episcopal Hospital, Brooklyn, N. Y., died in that institution at the age of seventy-four. Doctor Holmes became director of the hospital in 1916 and served in that capacity until his resignation in 1933.

LEONARD A. LUBBOCK of Princeton, N. J., has succeeded MAJ. A. GORDON CUMMINS as superintendent of Faxton Hospital, Utica, N. Y. Before going to Princeton, Mr. Lubbock made surveys of several hospitals in the East and has acted as co-administrator of a hospital in New Jersey. Major Cummins will return to private life.

DR. E. E. CLOVIS, a man of wide experience in sanatorium work, has been appointed superintendent and medical director of Ohio County Tuberculosis Sanatorium, Wheeling, W. Va., an institution of 40-bed capacity. The new building was dedicated last October. He succeeds DR. GEORGE VIEWEG, who resigned after twelve years as superintendent of the sanatorium.

HILDA McDONALD, superintendent of General Hospital, Penetanguishene, Ont., has resigned from that position.

MARJORIE DAVIS has become superintendent of nurses and principal of the school of nursing at the New England Deaconess Hospital, Boston. She has held a similar position with the New York Post-Graduate Medical School and Hospital.

DR. G. F. AMYOT, formerly of North Vancouver, is now in charge of the new hospital advisory service set up by the British Columbia government. The purpose of this service is to advise hospitals on technical problems, finance and management. Periodical inspections will be made. PERCY WARD, former manager of North Vancouver Hospital, is assistant to Doctor Amyot.

DR. LEWIS H. TAYLOR has been chosen superintendent of Sibley Memorial Hospital, Washington, D. C., succeeding the late CHARLES S. COLE.

DR. WINFRED OVERHOLSER, formerly commissioner of the Massachusetts State Department of Mental Diseases, has been appointed director of mental hospital research for the National Committee for Mental Hygiene, New York City. He will direct a national survey to ascertain the extent of research being made in institutions for the care of the mentally ill and to find new research clues worthy of development. Doctor Overholser taught psychiatry at Boston University School of Medicine for several years and has been lecturer at the Boston University School of Law since 1929. He has served as consultant to the National Crime Commission and as chairman of the committee on delinquents and prisons of the First International Congress of Mental Hygiene.

ELOISE SHIELDS, for five years director of nursing at New York Hospital, New York, has resigned. She has been succeeded by ELIZABETH BIXLER, recently educational director at Worcester Hospital, Worcester, Mass.

DR. JOHN F. REGAN has resigned as assistant superintendent of the North Dakota Hospital for the Insane, Jamestown, to become assistant superintendent of the State Hospital for Mental Diseases, Howard, R. I.

MRS. DORIS McCUNE has accepted a position as director of nurses in the Lubbock Sanitarium and Clinic, Lubbock, Tex., and will succeed LILLIAN WALTEMATE.

JOSEPH G. NORBY, formerly head of Fairview Hospital, Minneapolis, has been named superintendent of Columbia Hospital, Milwaukee, where he succeeds EARL R. CHANDLER.

DR. J. M. FERGUSON, medical officer in charge of the Veterans Hospital, Lexington, Ky., has resigned from that position on account of poor health. He has been succeeded by DR. LETCHER TRENT, chief medical officer at the Veterans Facility, Roanoke, Va.

DR. FRANK KOHN will resign from his position as superintendent and resident physician at Tulare County General Hospital, Tulare, Calif., when his term expires in June. He will enter private practice.

DR. ASA C. WATSON, England, Ark., has been appointed superintendent of the Benton division of the State Hospital at Little Rock, Ark.

Success Our Only Salesman

\$75,000 Raised for St. Mary's Hospital, Clarksburg, W. Va.

The firm of Ward, Wells & Dreshman employ no advance agents to sell to hospitals and other institutions our expert money raising services. Our business is built upon a continuous series of successful campaigns.

For example, last January we successfully completed a campaign to raise \$275,000 for St. Mary's Hospital, Huntington, W. Va. Sister DeSales, Superintendent of St. Mary's Hospital, Clarksburg, W. Va., shortly thereafter requested the same direction for a campaign to raise \$75,000.

The following message speaks for itself:

"Clarksburg, W. Va., April 21, 1937.

"Ward, Wells and Dreshman,
5115 R. C. A. Bldg., Rockefeller Center.

CAMPAIGN FOR ST. MARY'S HOSPITAL CLOSED TODAY AS MOST SUCCESSFUL CIVIC PROJECT IN HISTORY OF CLARKSBURG STOP OUR GOAL ACHIEVED AND THE WHOLE SPIRIT OF THE CITY IMPROVED AS RESULT OF CAMPAIGN STOP ONLY THE PERSEVERANCE OF YOUR REPRESENTATIVES COULD HAVE MADE THIS VICTORY POSSIBLE IN FACE OF EXTRAORDINARY DIFFICULTIES STOP WHENEVER WE REQUIRE CAMPAIGN LEADERSHIP AGAIN WE WILL CERTAINLY CALL ON YOUR FIRM.

SISTER MARY DESALES, SUPERINTENDENT"

Your hospital can have the advantage of our unparalleled success in money raising. To secure our services write us telling us of your needs. We will gladly confer with you and give you sound advice, without your incurring any obligation to employ our services.

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Profit FROM THIS JUICE HUNGER

Trujis offers alert managers the complete solution of the citrus juice problem. First—and always—high quality, for nothing but the choicest graded fruits are used—quick-frozen and vacuum packed in enameled cans. Experts select the fruits that make the best juice—Valencia oranges and lemons from the finest California orchards; grapefruit from selected California and Arizona desert groves—all recognized as premium grades for juice purposes.

Only a short distance from the luxuriant groves, the juices of these tree-ripened fruits are packed by patented process in a spotless plant at Pasadena. Quick freezing and vacuum packing retain all the vitamins, aroma and the natural richness that counts for flavor, appetite appeal, and satisfaction.

These natural juices are 100% pure . . . not heated . . . nothing added . . . nothing removed. They are constantly refrigerated until delivered for use. Always ready, they give you peak of season freshness every month in the year. They carry you over periods of scarcity and high prices with uniform quality and price. Get your daily supply . . . open a can . . . your service is ready.



CALIFORNIA CONSUMERS CORPORATION

Executive Offices: 230 West Jefferson Boulevard, Los Angeles, California

DR. RICHARD H. BENNETT has been appointed medical director of Brooklyn Home for Consumptives, Brooklyn, N. Y., succeeding the late DR. LUTHER F. WARREN.

DR. J. C. DUNN of Lewistown, Mont., is the new assistant superintendent of Montana State Hospital, Warm Springs, succeeding DR. EDWARD LIEURANCE.

DR. ANDREW WARNER, Twin Falls, Idaho, has been placed in charge of the administration of Idaho State Mental Hospital, Blackfoot, Idaho. DR. C. R. LOWE will continue in charge of the medical and surgical work at the hospital, it is reported.

DR. CHARLES E. K. VIDAL has retired as medical superintendent of Montana State Tuberculosis Sanitarium, Galen, Mont. He has been with the sanitarium for eighteen years.

DR. MAX CUTLER, director of the tumor clinic at Michael Reese Hospital, Chicago, will return May 10 from Peiping, China, after two months as visiting professor of surgery at Peiping Union Medical College.

KATHARINE FAVILLE, associate dean of the Frances Payne Bolton School of Nursing at Western Reserve University, Cleveland, will succeed MARGUERITE WALES as director of the Henry Street Visiting Nurse Service in New York City.

SISTER CLARINDA FORTIN has succeeded SISTER MARY DE L' EUCHARISTIE as Superior at Edmonton General Hospital, Edmonton, Alta.

DR. MCLAIN ROGERS has resumed control of the Western Oklahoma Baptist Hospital in Clinton, Okla.

DR. WILSON G. SMILLIE is the new head of the department of public health and preventive medicine at Cornell University Medical College, New York City.

DR. ROBERT E. LEE STEINER, superintendent of Oregon State Hospital, Salem, has announced his resignation, to take effect July 1. He has held the position for forty-nine years. The board of control has named DR. JOHN C. EVANS, for many years assistant superintendent at the hospital, to succeed Doctor Steiner.

DR. ROBERT R. SMITH, superintendent of Kankakee State Hospital, Kankakee, Ill., has resigned from that position. DR. GEORGE W. MORROW, his assistant, has become acting head of the institution. Doctor Smith will return to private practice in Mount Vernon, Ill.

JOHN L. BURGAN, former superintendent of the Abington Memorial Hospital, Abington, Pa., has been named superintendent of the Montgomery County Home, Black Rock, Pa. Mr. Borgan began his duties April 1.

ROBERT CARL BERLIN, senior member of the firm of Berlin & Swern, architects, Chicago, died April 18, at

the age of eighty-four. Mr. Berlin practiced architecture in Chicago since 1877 and was well known for designing and superintending the erection of hospitals.

DR. LEO M. MAGUIRE has been appointed chief medical officer in charge of the veterans' hospital at Fort Snelling, Minn.

GLENN W. FAUSEY, assistant superintendent and business manager for the Highland Park Hospital, Detroit, has been appointed superintendent of Pontiac General Hospital, Pontiac, Mich., effective May 1. He will succeed DR. C. A. NEAFIE, superintendent since 1934. Doctor Neafie, who also is director of public health, desired to be relieved of his hospital duties. He will continue as director of public health.

N. Y. Dietitians to Meet

The New York State Dietetic Association will meet May 20 to 22 in conjunction with the meeting of the New York State Hospital Association. Research in relation to dietary principles and problems of administration will be considered. Dr. Walter Eddy, professor of biochemistry at Teachers College, will speak on "The Progress in the Field of Vitamins," and Dr. Thomas Mackie of Roosevelt Hospital will discuss "Colitis as an Allergic Manifestation" at the opening session. The influence of a nutritionist upon the health of a community will be discussed by Dr. W. H. Sebrell, member of the Technical Commission on Nutrition of the League of Nations. Pauline Murrah, Red Cross Nutrition consultant will give a survey of nutrition in the New York City health department. Other speakers will be Dr. C. W. Munger, president of the American Hospital Association; Dr. Charles Gordon Heyd, president of the American Medical Association, and Boris Fingerhood, superintendent, Israel Zion Hospital, Brooklyn, N. Y.

Administration Course Given

A short course in hospital administration for small hospitals was sponsored by the Minnesota Hospital Association and given at the University of Minnesota on March 18 to 20. Subjects offered included hospital accounting, household management, laws, insurance, social security, personnel, community relations, publicity, staff relationships and collections. They were presented by, among others, Dr. Robin C. Buerki, superintendent, State of Wisconsin General Hospital, Madison; Paul Fesler, superintendent, Wesley Memorial Hospital, Chicago; Dr. F. G. Carter, superintendent, Christ Hospital, Cincinnati, and Dr. Bert Caldwell of the American Hospital Association.

Wellcome Fortune Dedicated to Scientific Research

Division of the Wellcome Foundation Limited under the will of Sir Henry Wellcome, British philanthropist, who died last July, will be, after personal provisions have been made, between two branches of research—scientific and medical, and museums and libraries.

Profits of the great chemical manufacturing company which will go to research cannot be estimated in figures. It will be run in the future, not for private or even for cooperative profit, but for the endowment of medical and allied scientific research and the upkeep of scientific institutions.

The will directs that two of the trustees shall always be men of standing and authority in medical and allied scientific research. Chosen for this position are Sir Henry Dale, director of the National Institute of Medical Research, who for ten years was associated with Sir Henry Wellcome as director of the Wellcome Physiological Research Laboratories, and Professor T. R. Elliott of University College Hospital. The trustees are given wide powers. Grants can be made either to individuals or to institutions.

To Build Out-Patient Department

A \$650,000 campaign to construct a new out-patient department building for the Hospital for Joint Diseases, New York City, has met with success and work will start at once. The demand for services has outgrown the facilities of the present out-patient department which was built in 1914 to accommodate 200 patients. During the last year the hospital was called upon to serve 700 patients a day.

White Plains Gets Gift

Building plans for the White Plains Hospital, White Plains, N. Y., have been aided by a gift of \$310,000 from Clarion B. Winslow, retired vice president of the F. W. Woolworth Co. This gift was the first in a campaign for \$1,200,000 with which the hospital hopes to replace its present thirty-year-old plant.

Half a Million Wanted

Mercy Hospital in Hempstead, L. I., is celebrating its Silver Jubilee by seeking a half million dollar fund in a public campaign with which to replace its present inadequate building with a complete 100-bed hospital building. Judge Thomas J. Cuff, of the New York Supreme Court, is chairman of the campaign.



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DIRECTOR

..... until you're in a job you'd love

They tell that nothing great was ever accomplished without great enthusiasm; they tell that all the things we want to do and get come as though naturally when we seek them eagerly, persistently, intelligently.

Doesn't *that* give courage?

If you and I are *what we are* and if what we are isn't *satisfying* to you or me, then maybe it is because we just live and grow and have become what we are without intent, without enthusiasm, uncontrolled.

If you *push*, something *gives*, in you or in the thing you push. If you *strike* or *pull* and *think* and *plan* and *act* with excited *enthusiasm* . . . always there is result.

Don't be satisfied with you. Get into the job

you'd love. Give all you've got to give. Study it. Find the ways to master it. *Boss* the things that *control* your progress. Do everything eagerly, earnestly, and your accomplishments will take care of themselves.

If you *aren't* in the job you love, make room for the person who *would* love it, who *would* lick it. Find the job that would give *you* thrills of satisfaction, find the one that'd make *your* eyes shine, make *you* get up in the morning in a hurry, the job that'd make *you* hum and whistle and sing as you work . . . for there *are* such jobs for *you*.

Ask us . . . we will help you find it. It is our great work . . . to find for hospitals and institutions the finest personnel in the land; to find for *you* the job you'd love!

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LITERATURE in ABSTRACT • • •

Conducted by E. M. Bluestone, M.D. and Joe R. Clemmons, M.D.

Locating Source of Rust

Before attempting to find the source of a rust mark, make sure that the spot is rust.* This can be determined by treating the stain with rust remover. After it has been established that the stain is rust, tests should be made of the different steps in the washing process to determine which is causing the stain.

Inspect the inside of the tank to find out whether the paint used is offering the proper protection. If not, the tank should be cleaned and painted or coated with one of the various forms of cement treatments. Rust can also arise in water or steam lines where these are used for heating the wheels. Steam lines should be blown out thoroughly before using after idle periods so that accumulated rust will not be blown into the washwheels. By holding a clean handkerchief over an open faucet for one minute it is possible to check the hot and cold water. If a brown deposit appears, the water supply needs checking to eliminate the rust. Poor handling methods might be the cause, such as use of trucks with rusty bottoms, exposed nails or screws.

*Laundry Questions and Answers, Rust Marks, Starchroom Laun. J. 44: 48 (Jan. 15) 1937. Abstracted by Margaret G. Reitz.

Conservatism in Wards

The author reviews the latest British report on standardization of ward construction, in the light of experiences of the past few years.* Mistakes embodied in steel and concrete are permanent and enduring; hospital planning warrants the most painstaking study.

In large wards of the old type, where beds are placed on either side of the ward at right angles to the wall, the practical criteria generally accepted are: wall space per bed, 8 feet; width of ward, 26 feet; height, 11-12 feet; total, 100 square feet per bed. There is no real justification for departing from these minimum standards for any reason. Variations in height affect building costs to the greatest extent.

In several new hospitals the building of two-bed glass cubicles with beds aligned lengthwise along the wall has been tried. The advantages are greater privacy, elimination of window glare and improved ventilation and heating. The critics of this new ward scheme claim increased difficulty of supervision by the nurse, diminished concentration of patients with

resultant greater traveling distance for staff, and increase in droplet infection possibilities. (sic)

The greatest innovations in hospital planning in Britain have been in the field of tuberculosis hospitals. The report by Sir Frederick Menzies advocates for general hospitals the return to the "normal" (old) type of ward construction, but does not specify whether this old-fashioned arrangement is the best possible.

The official report by the London County Council apparently represents the ultimate in conservatism in hospital planning.

*London County Council, Annual Report of the Council, 1935, Vol. IV (Part 1) Public Health—General and Special Hospitals. London: P. S. King & Son. Special Article, *Lancet*, 1: 225, (Jan. 23) 1937. Abstracted by J. Masur, M.D.

Air Conditioning Five Departments

The five most prevalent uses for air conditioning in hospitals are in nurseries for premature infants, in operating rooms, in oxygen therapy chambers, in heat therapy rooms and in the treatment of allergic patients.*

Extensive research has shown that maintenance of suitable temperatures with high relative humidity results in a striking reduction of the incidence of respiratory and digestive diseases in premature infants. Research at the Infants' Hospital in Boston established the best temperature to be 77° F. with sixty-five per cent relative humidity. Low relative humidity between twenty-five per cent and 50 per cent brought about unstable body temperature, less gain in weight, increase in incidence of gastro-intestinal disturbances and a rise in mortality. The ideal relative humidity was found to be between 55 per cent and 65 per cent.

Comparing results in unconditioned and air conditioned nurseries, the loss of weight appeared to vary inversely with the humidity. With natural humidity, weight loss was 12.4 per cent of birth weight but it was only 6 per cent with 50 to 75 per cent relative humidity. The length of time to regain this loss was less in the conditioned nursery. Incidence and severity of digestive syndromes with diarrhea, vomiting and other symptoms were twice as high under low humidity. Acute and chronic infections were the principal causative factors in death. In old nurseries the death rate from this cause was 26.5 per cent compared with 0 per cent under high humidity.

Air conditioning in operating rooms is mainly concerned with the welfare of the patient, the comfort of the operators and the safety of the whole procedure.

The introduction of ethylene in modern anesthesia and the increasing use of oxygen in combination with ether or ether-nitrous oxide mixtures has increased the danger of static sparks which might result from accumulation of frictional charges when the humidity is low. Most violent explosions occur in mixtures containing about 30 per cent ethylene or ether and 70 per cent oxygen. One means of preventing accumulation of static charges is humidification of air to between 55 and 60 per cent relative humidity. Artificial humidification, however, requires constant supervision, as a drop in humidity may prove disastrous.

Not much is known regarding the optimum air conditions necessary to maintain a normal body temperature under anesthesia and during the post-operative period but on the whole it seems that satisfactory temperatures are 80° in warm weather and 72° to 75° in cold weather with a relative humidity of 55 to 60 per cent in both cases. This gives comfort to the operator, increases the efficiency of the entire personnel and in warm weather reduces the danger of heat stroke in the patient.

There are three methods of administration of oxygen in use—nasal catheter, oxygen tent and oxygen chamber. The first method is simple and inexpensive but causes some discomfort to the patient. The second method is much superior although it has certain drawbacks, namely, the oxygen concentrations of 50 per cent or more are difficult to maintain and it is hard to keep temperature and humidity low enough to meet requirements under certain conditions.

The oxygen chamber is an airtight, sheet metal enclosure. Trap doors or curtains are provided for service and light is furnished through glass windows. The oxygen chamber is unquestionably more comfortable than either tent or nasal catheter. The patient is unhampered and the oxygen concentration, humidity and temperature remain constant. These three factors can also be regulated to suit the individual condition. However, the initial and operating costs are high and would probably be a liability for a small hospital.

Various methods of producing systemic fever have been used but the most effective one is the air conditioned chamber known as the "Kettering Hypertherm." This is an insulated cabinet with electric air heaters, an electrically heated water pan for humidification, a fan for circulating the air and a thermostat and humidistat for temperature control. Saturated or nearly saturated air, in the author's opinion, offers a safer method of pro-

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ducing artificial fever than hot dry air. Extensive research is now in progress on fever therapy and criteria for air conditioning are not definitely established.

Two methods are in common use for the treatment of hay fever, namely, desensitization and pollen filtration with or without air cooling. The former is preventive and in a few instances curative for all practical purposes; filtration or air conditioning methods give only temporary relief. It is also known that all cases are not caused by airborne substances and sometimes symptoms are actually aggravated by air conditioning. Despite these limitations, air conditioning methods have definite advantages in furnishing relief as well as offering an excellent means for diagnosis. Pollenfree air, however, can sometimes be obtained simply by filtration without air cooling. It has also been found that extreme changes in temperature will cause hay fever attacks. This is alleviated by the stabilizing of temperature. A comfortable range between 75° and 82° in warm weather according to prevailing outdoor temperature, and a relative humidity well below 50 per cent appears to be beneficial and desirable.

For hospital wards the problem is one of ventilation rather than conditioning. For the latter there is a wide variety of portable coolers designed to filter, cool and dehumidify the air without requiring changes in electric wiring or plumbing. Noise, an objectionable feature of these, is lacking in the multiple stationary cooling units with one or more central compressors in the basement.

*Yaglou, O. P.: Hospital Air Conditioning. *J. Ind. Hyg. and Tox.*, 18: 741 (Dec.) 1936. Abstracted by Margaret G. Reitz.

Temperature and Humidity Effects on Body Temperature

If the rise in body temperature from malaria fever is the primary condition resulting in the cure of certain diseases including syphilis and gonorrhea, then other means for elevating body temperature could be more satisfactorily used.*

In 1929, a group of physicians and engineers agreed that a satisfactory means of uniformly elevating body temperature was through proper control of the temperature and humidity of the environmental atmosphere. Studies made available a comprehensive record of physiologic reactions of persons over a wide range of relative humidity, temperature and air movement. In a small box it is a simple matter to determine suitable combinations of temperature and humidity in either still or moving air to give any desired rate of rise in body temperature.

A series of tests were conducted on five persons in saturated atmospheres

of 105° and 110° F. All but one showed a phenomenal increase in the leucocyte count of the blood paralleling the rise in body temperature, indicating that the increase in the leucocyte count might be an important factor in the application of fever therapy. The negative case, showing no material rise in leucocyte count, was a person of low vitality, who collapsed when his body temperature reached 102° F.

A most satisfactory box condition for giving fever therapy would be a saturated atmosphere. This gives a rapid rise in body temperature with a relatively low dry bulb temperature and similar low temperatures of all surfaces and objects which come in contact with the patient.

A high temperature water spray serves to elevate the temperature and moisture content of the air and to circulate it. The slight drop in air temperature from the point where it leaves the water spray to the box ensures saturation. The water spray gives sufficient air velocity to give two and one-half air changes a minute. The high temperature, humid air supplied at the top, and rapidly removed at the bottom, gives a temperature gradient of not more than 2°.

The air conditioning equipment is of the dewpoint control type, with a pump for recirculating water through an electric heater. A small amount of fresh water is added to keep down odors in the box.

Instruments record temperature of the hot water at the spray, the air in the box and the rectal or oral temperature of the patient.

Operation of the box: Turn on the hot water and raise the box temperature to 120° F. in 3 minutes. Keep at 120° F. for about one-half hour; the patient's temperature may be expected to rise from normal to 104° F. Drop the box temperature to 110° F. for 20 minutes; this may be expected to elevate the patient's temperature to 106° F. A box temperature of between 100° to 103° F. maintains the body temperature at 106° F.; the patient generates approximately 400 B.t.u. of heat per hour, which must be dissipated to the atmosphere in the box.

Clinical application of fever therapy has been satisfactory in most cases of gonorrhea. In addition to destroying the organism, the white blood corpuscles are increased. Relief from pain occurs after one treatment in women and with a full course pain recedes completely and does not recur.

In men, the relief of urethral symptoms such as pain, burning, is rapid and prevents complications. In both sexes arthritis caused by gonorrhea can be treated with fever therapy specifically. If treated early, there is no joint disability. In chronic cases, fever therapy frequently aids in restoring some function to the involved joint. Twelve to twenty-five hours, with sessions of three to five hours

duration, given at three to seven-day intervals are indicated.

Fever therapy arrests paresis caused by syphilis. Other manifestations of this disease may be treated with fever together with the various chemicals. In paresis from twenty-five to fifty hours produce the best results with five-hour sessions given every week.

In chorea fever therapy has done much to bring about recovery and shorten the course of the disease. Eight or nine sessions at 105° to 106° F. for three to four hours are suggested. Treatment of this disease is comparatively recent and few statistics are available.

Fever therapy has been tried in multiple sclerosis without striking results.

With one case of Parkinson's syndrome the tremor of the hand ceased after twenty-five hours of fever between 105° and 106° F.; a single case proves nothing.

A weak heart, high blood pressure, general debility or hardened arteries contra-indicate fever therapy. Blood counts and bacteriologic studies are made before starting treatment. A sedative is administered in the box, to minimize danger of delirium, the face and head are cooled by an electric fan and ice applied directly. The chloride and fluid loss is great; 0.6 saline solution is given by mouth. Rectal temperatures, pulse, and respiratory rates are taken every ten minutes. Blood pressure readings are made at intervals. The pressure, at first elevated, drops as the vessels dilate. No covers are used, permitting freedom of movement. A small dose of opiate is administered for restlessness. Following fever therapy glucose and saline solution are given by vein as a stimulant and food. Occasionally herpes develops on the lips. Cyanosis is controlled by administration of 90 per cent oxygen and 10 per cent carbon dioxide.

*Houghton, F. C., Ferderber, M.B., and Gutberlet, Carl: Fever Therapy Induced by Conditioned Air, Heat, Pip. and Air Condi. 9: 2, 115 (Feb.) 1937. Abstracted by J. R. Clemmons, M.D.

Stains From Greases

Fresh grease stains of various types such as vasoline, mineral oil and ointments can be removed by grease solvents used in dry cleaning, or by carbon tetrachloride, chloroform, trichlorethylene and others.* When the stains have been set by washing or ironing the best method is a mixture of wet and dry solvents. A good solvent can be made by dissolving soap in pine oil and diluting the mixture with a grease solvent or carbon tetrachloride. Similar results can be obtained by adding 4 ounces of oleic acid to a gallon of grease solvent. After the grease stain has been loosened it must then be removed by regular washing process.

*Laundry Questions and Answers, Ointment Stains, Starchroom Laun. J., 43: 48 (Dec.) 1936. Abstracted by Margaret G. Reitz.

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Building Accident Resistance

The importance of health conservation and prevention of illness is stressed.* The safety program should include a study of such accidents.

Respiratory and digestive disorders are among the leading causes of suffering among industrial workers. There are three times as many accidents off duty and five times as many days lost from these causes.

Automobile traffic and transportation accidents are real menaces. Some persons are so-called "accident-prone," just as some individuals are susceptible to certain ailments. Safe methods of thinking will build up accident resistance.

The importance of an industrial health program is stressed. Generally, a well rounded industrial health program comprises six major activities as follows: sickness records; communicable disease control; tuberculosis control; occupational disease and accident control; personal and environmental hygiene; general health publicity.

Early physical examinations and diagnosis are necessary in the development of the tuberculosis program. Good health and safety habits among employees should be encouraged.

There is a definite trend towards increasing compensation coverage due to the inclusion of certain occupational diseases in addition to the usual accident injuries.

Improper methods of painting and cleaning have been found to be responsible for naphtha and benzol poisoning. Where such hazards exist frequent physical examinations will reveal early symptoms. Prompt attention to minor wounds will prevent serious infections. Regular magazine or house organ articles should be a part of the program. Personal health guidance of the working force should be an essential part of the department head's routine.

*Bristol, Lawrence D.: Health Enemies in Industry, Safety Engineering, March, 1937. Abstracted by J. Goodfriend.

When Buying Fire Equipment

When purchasing fire fighting equipment it is necessary to consider the type of fire likely to take place, its location and local conditions.*

Foam is applicable for extinguishing fires in highly inflammable liquids and acts by spreading and blanketing the fire so that oxygen necessary to support combustion is kept away. Foam may be applied adjacent to the fire as a preventive.

Commercially the most common apparatus is the 2½-gallon cylinder extinguisher, wall supported or mounted on a pair of wheels. Extinguishing systems for industrial installations are composed of one or more units and operate automatically by the use of a fusible link or heat actuating device. For larger installations dry foam gen-

erators are used. The operation is continuous as long as water and powder are available.

Fire extinguishers using bicarbonate of soda and sulphuric acid mixed produce a pressure sufficient to throw a stream of neutralized soda solution some thirty to forty feet and are effective as first aid for free burning fires. The action is wholly cooling and has no blanketing effect.

For unheated parts of a plant anti-freezing apparatus is similar to the extinguishers of conventional appearance. The liquid is a calcium chloride solution. It is expelled by gas generated by chemicals contained in a cartridge which is broken upon inversion of the extinguisher. The extinguisher is suitable for free burning fires only and is safe for temperatures as low as 40 degrees below zero.

Vaporizing liquid is forced out of the container by means of a pump. It vaporizes immediately upon contact with the heat of the fire and the gas which is formed has a blanketing effect. It may be used for small and confined oil fires. The chemical is carbon tetrachloride. It is not an electrical conductor, stands temperatures of 50 degrees below zero and does not damage fabrics or corrode metals. The usual size of the extinguisher is one quart. A larger size, one gallon, is designed especially for power houses where electrical fires are likely to occur. These are operated by compressed air in a separate cylinder provided with a gauge to indicate the pressure.

Carbon dioxide is the best extinguishing agent available for electrical fires because there is no liquid which can damage insulation or dissolve any insulating material in use. Low temperatures have no effect on it. These extinguishers may be had in portable cylinders or a group may be installed and piped to the area to be protected. The operation is of the manual or automatic type.

The clear water type of extinguisher is good for free burning fires only. It is discharged by carbon dioxide gas by inverting the extinguisher.

In the education of employees in the use of equipment, charge certain individuals in each department or hazardous area with responsibility and leadership and train accordingly. A particularly successful plan is to take advantage of the period of annual recharging of extinguishers as the time for demonstration and training. At this time assemble the employees in a space adjacent and there build fires of different nature and let the men actually operate the apparatus and put out the fires themselves. The night watchman should attend these demonstrations.

Foam and soda acid types of extinguishers should be recharged yearly. The antifreezing type does not need recharging. Add water to the solution once a year to bring it up to the re-

quired level. The same is true of the clear water extinguisher. The carbon tetrachloride apparatus does not need annual recharging as there is no chance for the liquid to evaporate and it is a stable compound chemically. Observe the pressure gauge on the extinguishers of this class which are operated by compressed air. The carbon dioxide type should be weighed once a year to make sure that there has been no loss of gas.

The proper placing of fire protection apparatus and the number of units required against different kinds of risks are specified in coded rules of the National Fire Protective Association. It should not be necessary to travel over 200 feet to reach a fire extinguisher and, in severe conditions, 75 feet.

When purchasing fire protection equipment it is essential to make sure that it is approved by the Underwriters Laboratories for the use of which it is intended.

*Westbrook, Francis A.: Buy Fire Extinguishers to Fit the Hazard, Purchasing 5: 10 (Jan.) 1937. Abstracted by J. R. Clemmons, M.D.

For Contented Employees

The following principles are the indispensable basis for any program of successful employee relations. This had been the experience of Procter and Gamble after one hundred years in business.* First, there should be constant consideration of the welfare of the employee. The result of this principle will be a steady job.

Second, management should make it possible for every employee to become a capitalist in fact, not merely in theory or political creed. The employee should be helped to save money and to keep it.

Third, every employee should be able to look forward to a small old age pension from his company. If the first two principles are carried into effect, the third principle becomes easy to apply. The greater the degree of financial independence, the less the need for sizable retirement payment.

The company feels that good relations between employees and administration have prevented labor disputes and have been gained without great cost to the company.

The employees in this organization do not receive cash bonuses. They contribute 5 per cent of their wages for six years and the company returns 10 per cent at the end of that time. The employees own stock in the company equivalent to the amount of one year's wages.

Other helpful benefits are the half-holiday on Saturday, sick benefits, the employee conference plan and a week's vacation with pay every year.

*Deupree, R. R.: Good Employee Relationships Rest on Three Basic Principles, Food Industries, Feb. 1937. Abstracted by Ida D. Winaker.

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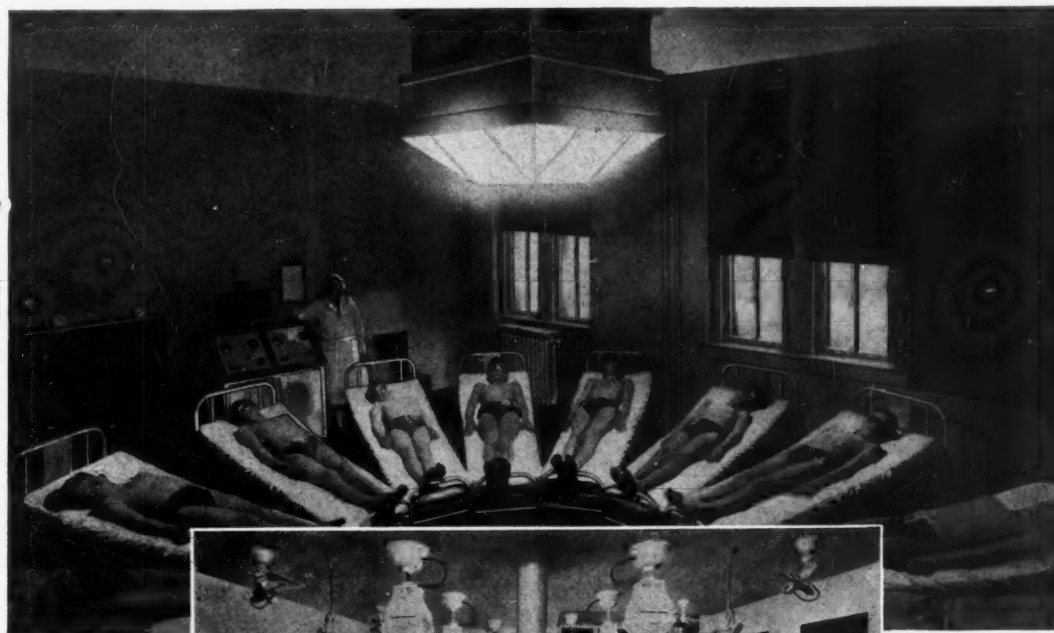
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BOOKS ON REVIEW

LIBRARY HANDBOOK FOR SCHOOLS OF NURSING.
New York City: National League of Nursing Education.
1936. Pp. 264.

This book has the distinction of being the first of its kind compiled especially for schools of nursing. The preface, written by Isabel M. Stewart, chairman of the central curriculum committee of the National League of Nursing Education, states that this committee decided early in its work that if the new curriculum were to be administered effectively better libraries must be available to instructors as well as to students.

In January, 1936, a sub-committee on the nursing school library was appointed, with Marian Rottman Fleming as chairman, to make a four months' study of the needs of nursing school libraries and to prepare material to supply these needs, as far as was possible in the time allotted. "A Library Handbook for Schools of Nursing" represents the remarkable accomplishment of this committee in four months.

The book is divided into three parts and offers ready information on problems which present themselves to those carrying on the work of establishing or building up libraries for schools of nursing.

Part 1: "Administration of a Nursing School Library," presents in small paragraphs, subjects which would take at least a course of instruction in library school training or practical experience extending over months to master, as, for example, care of pamphlets, reprints, etc.; care of periodicals; library records; mending and binding books. It also contains a short reading list, an excellent list of fifty periodicals recommended for a school of nursing library compiled by Ethel Wigmore, and equally excellent lists of sources of free and inexpensive material by the same compiler. These lists should prove valuable to instructors, supervisors and students, as well as to those administering the library.

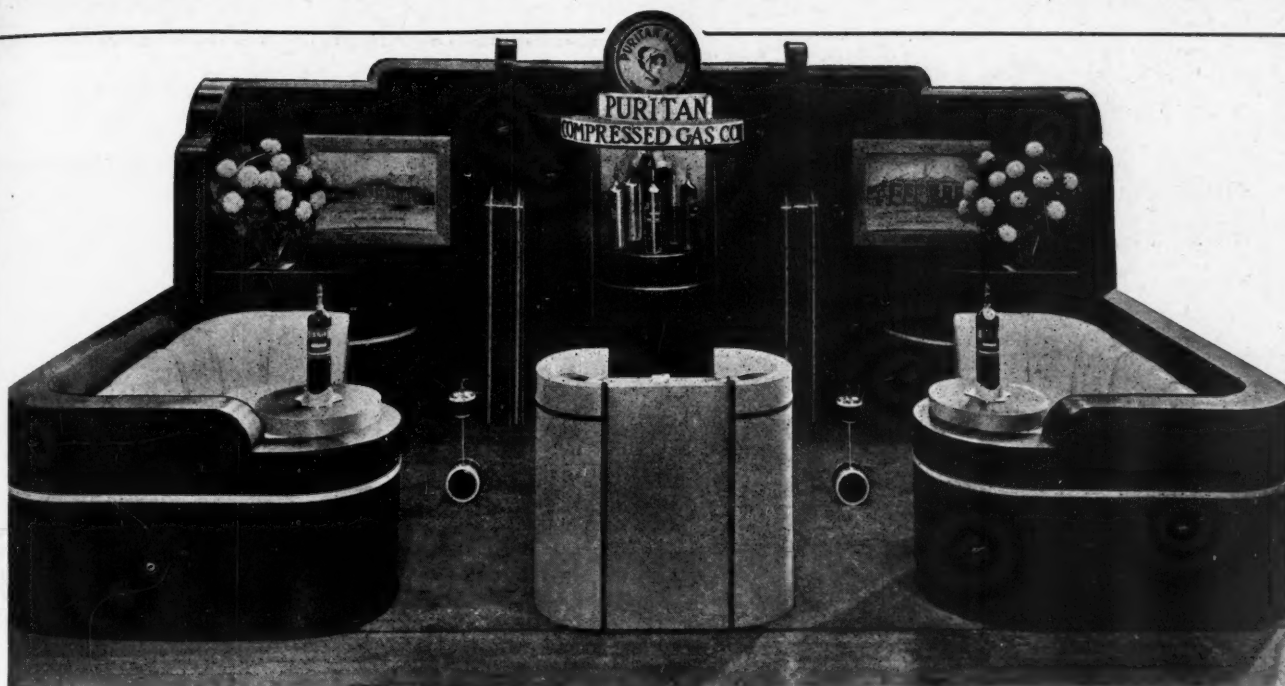
Part 2: The "List of Subject Headings" prepared by Mary Casamajor and Ann Doyle for Bellevue School of Nursing is given in sufficient completeness and detail to be of usefulness to a person, even without library training, in building up a nursing school library.

Part 3: "Bellevue Classification Outline," especially designed to meet the needs of a school of nursing library is published in this section. At the end is a small general index which adds to the usefulness of the book.

The authors state definitely that the library handbook is offered as a guide, rather than a manual of procedure. It should, I think, serve the administrator of a nursing school library in much the same way that the league curriculum is intended to serve the administrators and teachers engaged in planning courses of study.—ELIZABETH W. ODELL.

SICKNESS AND INSURANCE. *By Harry Alvin Millis.*
Chicago: University of Chicago Press. 1937. Pp. 166. \$2.

This compact study gives a competent and well digested review of the economic problem of sickness, experience with compulsory health insurance in Germany, Great Britain and France, and a proposed program for the United States. Professor Millis, who is chairman of the department of economics at the University of Chicago, has done a competent job. Hospital administrators will find the book of value.—ALDEN B. MILLS.



You are cordially invited to visit with us during the meetings of the

**AMERICAN MEDICAL ASSOCIATION
AUDITORIUM, ATLANTIC CITY, N. J.
JUNE 7-11 BOOTH No. 26**

You will want to see our most interesting exhibit of "PURITAN MAID" gases, including our **Cyclopropane**, produced by the new and improved process developed at Purdue University, and manufactured by the **Mallinckrodt Chemical Works**, of which product we are the exclusive distributors.

PURITAN COMPRESSED GAS CORPORATION

Manufacturers and Distributors of Oxygen Tents and Other Therapy Equipment — All Types of Anesthetic Gas Machines — Resuscitators and Inhalators — Soda Lime.

Member Hospital Exhibitors Ass'n

GOOD HEATING

Comfortable room and ward temperatures are important in hospitals—and heating comfort, to the greatest possible degree, is the contribution of DIFFERENTIAL HEATING to hospitalization.

No matter how the weather fluctuates, DIFFERENTIAL steadfastly maintains its straight-line production of comfort without frequent window or valve adjustments with the utmost fuel economy. Thus air is not vitiated, "scorched" by excessive radiator temperatures. Consequently air conditioning to the Hospital's requirements is greatly simplified.

This automatic adaptation of radiator temperatures to all weather variations relieves hospital management of concern both for the performance and the cost of heating and these desired temperatures amplify the efforts of the medical staff.



May we send you a book on "Sub-Atmospheric Steam Heating"? Ask for Bulletin 125H.

THE SURGEON
and NURSE

DUNHAM
Differential
HEATING

C. A. DUNHAM COMPANY 450 EAST OHIO STREET **CHICAGO**

Served HOT...



This
"Protective Food Drink"
 induces sound,
 natural sleep

THERE ARE two reasons why a night-cap of Cocomalt, the protective food drink, helps to promote sound, refreshing sleep: **1.** Taken hot it helps draw the blood from the head. **2.** While it is distinctly a "food" it imposes no digestive strain.

Dietetically, Cocomalt provides highly desirable food essentials in a particularly tempting and delicious form. Because Cocomalt is a food, not a medicine, it can be safely used by young and old alike—from children to adults of advanced age.

Each serving of Cocomalt in milk provides .33 gram of Calcium, .26 gram of Phosphorus, 5 milligrams of Iron in readily assimilated form and 81 U.S.P. units of Vitamin D. Cocomalt is sold at drug and grocery stores in ½-lb. and 1-lb. purity-sealed cans. Also, for professional use, in 5-lb. cans available at a special price.

Cocomalt is the registered trade-mark of R. B. Davis Co., Hoboken, N. J.

Would You, as a Doctor or Nurse, like to try Cocomalt?

... We'll gladly send you or your hospital superintendent a trial size can of Cocomalt. The coupon makes it easy for you to ask for it.



R. B. DAVIS Co., Hoboken, N. J.
 Dept. N-5.

Please send me a trial size can of Cocomalt, Free.

Name _____

Street and Number _____

City _____ State _____

NEW PRODUCTS...

Clear and Colder

Colder than an income tax collector's heart is the dry ice frozen in ten seconds, 'tis said, by the "snow-man" freezer, product of the C. H. Hill Manufacturing Company, 210 South Avenue, Cranford, N. J. The freezer which is a small, compact, automatic machine for producing solid carbonic gas, has a variety of uses in the hospital, particularly in the laboratory—it maintains serum and certain germs in frozen condition for storage; maintains temperature below freezing point in chemical laboratories; freezes skin tissues to avoid decay and produces a lower temperature than is obtainable with natural ice when such is desired.

Collapsible Carts Save Space

Zip! it's open. Zip! it's closed. Between zips it's a highly serviceable carry-all truck for hampers, trays or what do you need it for? Folding Metal Products Co., Fremont, Ohio, are responsible for this new device called "fold-way." Its outstanding feature, of course, is the "foldability." When not in use, three fold-way trucks occupy but five square feet of floor space. It likewise permits increased floor traffic as when folded it is rolled to one side or into a linen closet or other recess, completely out of the way and out of sight.

The mechanical features of the truck which its manufacturers would particularly like to have noted are (1) it is instantly and easily opened or folded; (2) it automatically locks in open or closed positions; (3) it is interchangeable wholly or in part from one to another different type of hamper and tray trucks; it has heavy duty, free wheeling, hard rubber, noiseless, oversize casters; extra strong, light all-steel frame and sturdy pressed steel trays and heavy duck and canvas bags. (The adjectives are theirs).

There are two other members of the fold-way family in which you might be interested: a wheeled stretcher and a bed.

Your Presence Is Requested—

With National Hospital Day rolling around again, maybe you'd like to invite your friends and neighbors to drop around and pay you a nonprofessional call. If you are planning to hold open house that day and want to let people know it, try writing a letter on the special National Hospital Day stationery offered by Physicians' Record Company, 161 West Harrison Street, Chicago. Not only will they supply letterheads with your hospital's name printed on them, but they are willing for a small fee to multi-graph a letter of twenty-five lines for you. Folders and posters designed to make the public Hospital Day conscious are also available.

Portable Comfort

There are a lot of words in the dictionary that rate more space than the simple two-word compound, air conditioning. That, however, is because the dictionary doesn't give all the synonyms for it such as "comfort and well-being" and all the other adjectives that describe one's sensations on entering an air conditioned room or on taking the air conditioning with one into the room. Because that, too, is possible, what with portable units that



"Like Nurses"

—they are trained in the
sanitary handling of these
"FINER FOODS"
which are packed with
"HOSPITAL CARE"

Hospitals are quick to appreciate the exacting control under which all Monarch Finer Foods are packed.

Those who visit these modern sanitary plants, leave them with one word of unanimous approval . . . "Now, we shall enjoy Monarch Finer Foods more than ever before."

To be packed under the Monarch Lion Head Label is also a guarantee of selected quality.

Fruits, sun-ripened and packed at the very hour of their peak goodness. Vegetables, "fresher than fresh," because packed within a few hours of picking.

Each Monarch Finer Food is "grown where Nature does her best." Each tin is a solid pack of finer quality. Each brings you more servings . . . more satisfaction . . . and more good will from your patrons.

Write, wire or phone (SUPERIOR 5000) for representative to call.

Institution Department

REID, MURDOCH & CO.

PACKERS AND DISTRIBUTORS

Dept. MH-5

Chicago, Illinois



FRUITS
WITHOUT
SUGAR

A
Selection
of
Dietetic
Foods

Also of interest is a fine and varied selection of solid pack pie fruits under our Red Lily Label.

"Quality
for
84 years"

A selection of Dietetic fruits and vegetables is also provided under the Monarch Label.

Vol. 48, No. 5, May, 1937

CONQUEROR LINE

Presents a New
Development in

MAYO INSTRUMENT STANDS



MADE COMPLETELY OF STAINLESS STEEL

EQUIP FOR PERMANENCE INSTEAD OF REPLACEMENT — INSTALL STAINLESS STEEL EQUIPMENT

● Not just the tray alone, but the ENTIRE STRUCTURE of this attractive Instrument Stand is made of bright, pure and shining Stainless Steel.

● Chip-free, rust-proof, non-tarnishing Stainless Steel, used throughout the Stand, provides the absolute cleanliness and sterility so vital to Operating Room technique. Stainless Steel, unlike enameled or plated surfaces, can never become shabby, worn or unsanitary. Maintenance expense is eliminated and enduring attractiveness assured.

● Hospitals are now furnishing Operating Rooms with equipment made entirely—not just in part—of bright, enduring Stainless Steel. Write, without obligation, for a typical Operating Room lay-out and thus secure complete illustrations, specifications and prices on this up-to-date equipment.

● A complete display of our Stainless Steel Operating Room Equipment may be seen by hospitals in the Southwest at the showrooms of the Denver Fire Clay Company, Denver, Colorado.

THE CONQUEROR LINE



OF HOSPITAL EQUIPMENT

S. BLICKMAN, INC.

MANUFACTURERS OF HOSPITAL EQUIPMENT

WILMINGTON, N.J.

AN EASY-TO-DIGEST ENERGY-FOOD— WITH CRISPNESS ADDED



BECAUSE they're always crisp and oven-fresh . . . because they have a tempting flavor that can't be copied . . . because they're an excellent energy-food, exceptionally easy to digest . . . Kellogg's Corn Flakes are ideal to serve your patients, now that spring is in the air.

Every one likes the refreshing goodness of Kellogg's at this time of year. Serve them safely at any time of the day. Extra good with fruit added. The individual packages are convenient.

Kellogg's are always oven-fresh in the patented WAXTITE inner wrapper. Order from any jobber.

**Nothing takes the place of
Kellogg's CORN FLAKES**

roll smoothly around on casters and can be plugged into any light socket.

One of the more notable of these portable coolers is the new Vitalaire, manufactured by Ice Cooling Appliance Corporation, Morrison, Ill., a beautifully finished piece of furniture which blends pleasingly with the landscape. Ice is used as the cooling element of this unit, 300 pounds of it when fully loaded. The cheapest ice obtainable, such as broken, chipped and white ice which can be purchased very inexpensively may be used. The cooler is equipped with a one-twentieth horse power two-speed motor, either A.C. or D.C. as specified.

Vitalaire, its makers assert, is designed to cool and condition efficiently the air in a space from 1,800 to 2,400 cubic feet.

"More Storage Space, Please!"

If your fiscal year ends in June (or whenever it does end) you'll probably be transferring records, and just as probably your file clerks will be howling for more storage space. Comes at this crucial moment the All-Steel-Equip Company, Inc., of Aurora, Ill., with the new extra-capacity "Aurora" steel transfer case. The new case, All-Steel-Equip asserts, is built for the storage of old records of all sorts and has been designed as a unit complete in itself but usable with others in a storage system. A simple but ingenious construction feature, involving nothing to mar the smoothness of the outside of the case, allows these transfer cases to be built into nontipping stacks without the use of tools, lugs or bolts. The case is of maximum depth, 27 1/2 inches.

Hear! Hear!

A wrong number is about the only by-product the layman would expect to get from the telephone, but telephone engineers have shown the way toward furnishing hearing aids to the human race which heretofore has accepted deafness as one of those afflictions about which nothing could be done. They have also devised ways and means of analyzing various forms of hearing deficiencies and by these analyses can indicate the form of hearing aid which will provide the greatest relief in individual cases. The purpose of audiometric measurement is to determine at a given pitch or frequency the slightest sound the person under test can hear, and the 6A Audiometer, designed by the Bell Telephone Laboratories and manufactured by Western Electric Co., 195 Broadway, New York City, represents, it is stated, distinct advances in the art of audiometric measurement.

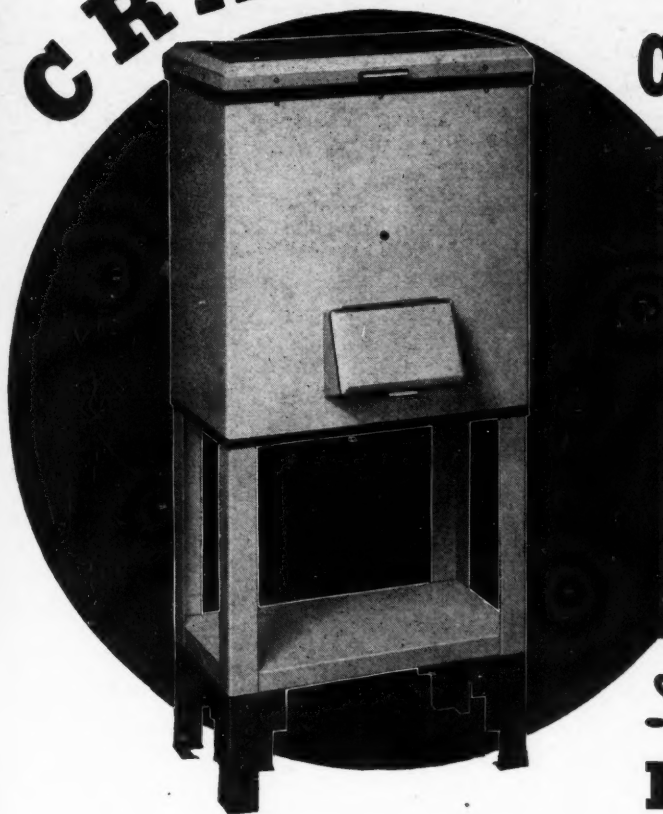
Its range of pitch is variable from a deep bass note of 100 cycles through all the intermediate notes up to a high pitch of 10,000 cycles. Accurate bone conduction tests of either ear can be made separately by means of the "masking" method. This is a process of eliminating perception by one ear while testing the other. Another improvement permits conversing with the patient through a microphone accessory. While the increased power of this instrument permits measuring greater hearing losses than heretofore has been possible, states Western Electric, the new equipment is smaller and lighter. It requires no batteries, operating on convenient A.C. or D.C. lighting supply.

Trade Literature

Toast, Hot and Savory—Have you a toasting problem? Have you, in fact, ever been embarrassed by a patient who says, with the nasty leer usually reserved for the dietitian when she makes her rounds with the day's menus, "It would be a nice change to get a decent piece of toast in this place"? Savory Appliances, Inc., 591 Ferry Street,

CRACKED ICE . . .

CLEAN—SANITARY

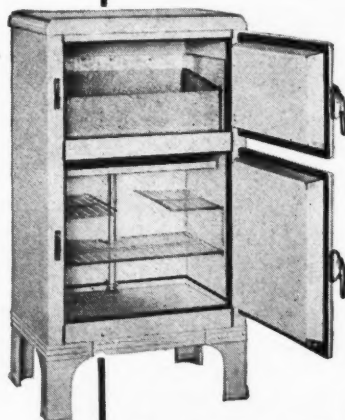


*always conveniently
available when dis-
pensed by the*

**SANITARY ICE
CONTAINER . .**

Designed especially for
HOSPITAL SERVICE

... and here's a NEW
**DOUBLE PURPOSE UNIT
THE SANITARY DUPLEX**



A combination refrigerator for light diet foods and drinks and a practical ice container providing economical storage for cracked ice. Install several of these new, time- and step-saving units in your hospital . . . at strategic points on each floor. Adequate shelf space (more than 6 sq. ft.) for all urgent demands. A boon both to patients and nursing staff.

Built in accordance with the most scientific principles of refrigeration and economy.

Constructed of rust-resisting galvanized and galvanized steel. Holds 50 lbs. of crushed ice. Dupont, White DuLux high-baked two-coat outside finish. Only \$49.50, complete with ice-scoop . . . f.o.b. Milwaukee.

This specially built ice container becomes an indispensable part of your hospital equipment once it is put into service.

Filled with 50 pounds of clean cracked ice, it provides the handiest possible means for storing and dispensing ice for ice packs, etc. Ice is put in at the top, scooped out at the bottom. Only the scoop comes in contact with the ice, thus eliminating the possibility of cross infection.

Container is made of heavy gauge steel, with outer wall finished in baked auto enamel. Rubber gaskets on top and side ice doors not only provide extra protection against melting of ice, but also insure quiet . . . both in filling, and dispensing. Walls and bottom are thoroughly insulated. Air-tight, water-seal drain. Capacity: 50 lbs. of cracked ice. Height of stand: 26". Container: 24" high, 22½" wide, 12" deep.

Complete, with stand and scoop.....\$38.75.

Just two of several thousand items supplied by Will Ross which include "everything for the hospital but food and drugs". Consult your Will Ross catalog . . . or the Will Ross salesman when he calls.

WILL ROSS, Inc. 3100 W. CENTER STREET
MILWAUKEE, WISCONSIN
Manufacturers and Wholesale Distributors of Hospital Supplies

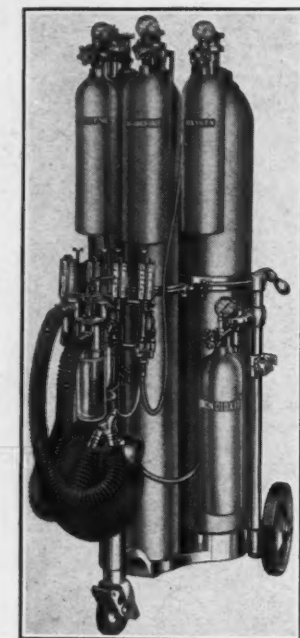
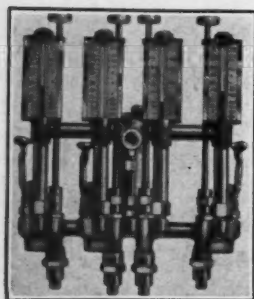


A 2011-1P

HEIDBRINK

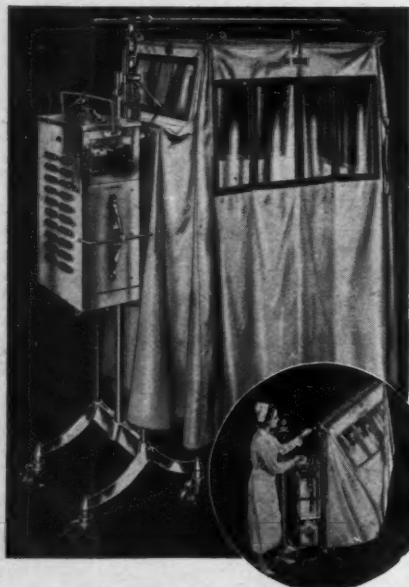
APPARATUS FOR GAS ANESTHESIA

The unequalled performance of the Heidbrink Kinet-O-Meter insures better results, at greatly reduced costs. Its many features simplify administration and develop the confidence of the operator.



Simple dry-float flowmeters (shown at left) control, measure, register and deliver each gas independently and accurately.

OXYGEN TENTS



Three models—two motorized and one motorless—are presented for 1937. They embody many innovations and every feature of practicability.

Any nurse can perform every duty incident to the application, operation and adjustment of any Heidbrink Tent.

Descriptive literature free upon request.

HI-CO

THE HEIDBRINK COMPANY
MINNEAPOLIS MINNESOTA

Newark, N. J., has been in the business of solving toast problems with gas for quite a while, and now has started to offer electrical solutions. These electric toasters range in capacity from 360 slices of toast per hour to 720 slices, every slice golden brown, crunchy and perfect, says Savory. Both the electric and gas toasters, as well as other appliances of Savory, are described in detail in their new catalogue, available on request.

Yes, We Must Have Bananas—"Bananas Take a Bow" is the name of a new booklet put out by the Fruit Dispatch Company, Pier 3, North River, New York City. Dietitians who must bow to the demand for bananas will undoubtedly be glad to have it and learn all the tricky ways of dressing up this popular fruit (or maybe it's a vegetable). The pamphlet contains twenty-six specially selected recipes as well as the latest information on "da banan." A considerable portion of the booklet deals with the cooking of the banana—fried, broiled, sautéed or baked.

Hints on Hospital Wardrobes—It just isn't possible to make patients' gowns (those dinky things that come half way to the knee and make you look like an immigrant who got wet coming over) stylish. But it is possible to make them comfortable and serviceable and this is the aim and end of Marvin-Neitzel Corporation, Troy, N. Y. Many shapes and sizes of these are demonstrated in the new Marvin-Neitzel catalogue as are doctors' operating gowns and suits, laboratory coats, interns' uniforms and nurses' uniforms. A workman is as good as his tools, reflects Marvin-Neitzel, and hospital clothing is an important tool, which is why such care and skill are put into the making of their "Hospital-Tested" garments. Write for the catalogue if the hospital wardrobe needs replacing.

Beauty Treatments for Rugs—Rug beauticians could probably hold forth for hours, were they given a chance, on the damage done to rugs and carpets when they are allowed to become thoroughly impregnated with dirt and grit. An honest-to-goodness bath at least once a year is really necessary to keep them in condition and prevent them from becoming brittle and deteriorating. We don't pretend to be an authority on the subject, but the Hild Floor Machine Co., 1313 West Randolph Street, Chicago, is. They know all about rug shampooing and how to keep your carpeted floors looking their Sunday-best. Furthermore, they are willing to impart their trade secrets to the listening public via a recent handbook on the subject, informatively titled, "How to Save Money With Hild System Rug and Carpet Cleaning and Dyeing."

Springs vs. Mattress—a Draw—Which is the more important—good springs or a good mattress? Good springs aren't much help if the mattress is lumpy; and the best mattress is at a disadvantage if the springs have fallen arches. So it would seem advisable to have the best of both and avoid complications. Catalog E of the Inland Bed Co., 3921 South Michigan Avenue, Chicago, sets forth a very complete line of springs and mattresses for hospitals, as well as the beds themselves. Also described and illustrated are diverse other items of furniture, including dressers, chairs, bedside tables and such. A handy order blank on which you can jot down the items that strike your fancy is enclosed with each catalogue.

Unusually Attractive—A very handsome job is the new brochure of Hospital Appliances, Inc., Pittsfield, Mass. Between its cream and blue covers are pictorially presented the MacEachern obstetric table, the Autopan bed and the Comper knee and foot rest, all well and favorably known.